State of Montana
Office of the Legislative Auditor

Performance Audit

Medicaid Long-Term Care Program

Department of Social and Rehabilitation Services

This report contains recommendations for changes in the operation and management of the Medicaid Long-Term Care program. The recommendations include:

- SRS review all components in the reimbursement formula and rebase and recalculate components in the operating rate for future use.
- SRS use denial reports to determine why providers are making errors in claims and use information to improve provider relations.
- The Medicaid Bureau actively monitor the contract with the Montana-Wyoming Foundation for Medical Care for utilization reviews of long-term care facilities.

Office of the Legislative Auditor
Room 135, State Capitol
Helena, Montana 59620

85P-12

PERFORMANCE AUDITS

Performance audits conducted by the Office of the Legislative Auditor are designed to assess state government operations. From the audit work, a determination is made as to whether agencies and programs are accomplishing their purposes, and whether they can do so with greater efficiency and economy. In performing the audit work, the audit staff uses audit standards set forth by the United States General Accounting Office.

Members of the performance audit staff hold degrees in disciplines appropriate to the audit process. Areas of expertise include business and public administration, statistics, economics, computer science, and engineering.

Performance audits are performed at the request of the Legislative Audit Committee which is a bicameral and bipartisan standing committee of the Montana Legislature. The committee consists of four members of the Senate and four members of the House of Representatives.

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May 1986

The Legislative Audit Committee
of the Montana Legislature:

This is our performance audit of the administration of the Medicaid long-term care program of the Department of Social and Rehabilitation Services.

This report contains recommendations concerning department procedures in relation to administration of the Medicaid long-term care program. Department responses are contained at the end of the report.

We wish to express our appreciation to the staff of the department for their cooperation and assistance.

Respectfully submitted,

Scott A. Seacat
Legislative Auditor

PERFORMANCE AUDIT REPORT

MEDICAID LONG-TERM CARE PROGRAM

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

May 1986

Report Number 85P-12

Members of the audit staff involved in this audit were: Dave Gould, supervisor; Mary Reynolds, auditor-in-charge; Mike Wingard, senior; and Angie Grove, staff auditor. Additional information on the audit can be obtained by contacting the Office of the Legislative Auditor (406) 444-3122.

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OFFICE OF THE LEGISLATIVE AUDITOR

PERFORMANCE AUDIT OF THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

MEDICAID LONG-TERM CARE PROGRAM

Executive Summary

This report is the result of our performance audit of the Medicaid long-term care program administered by the Department of Social and Rehabilitation Services (SRS). The objectives of this audit were to determine if:

1. reimbursement rate setting procedures and related standards/rules are reasonable, and supported by documentation;

2. Medicaid long-term care providers are reimbursed at the amounts established by the department and if reimbursement is timely;

3. procedures are in place, and are functioning as described to ensure long-term care Medicaid recipients are receiving adequate care; and

4. the long-term care program and the Medicaid Bureau (responsible for administering the program) are being administered in an efficient and effective manner.

Background

In December 1985 there were 99 licensed long-term care facilities in Montana receiving Medicaid funds. Ninety-six facilities are nursing homes, including the Center for the Aged and Montana State Hospital (Galen and Warm Springs are considered two facilities). The Montana Developmental Center at Boulder, Eastmont Human Services Center, and Happy Acres - Ronan, receive Medicaid funds as intermediate care facilities for mentally retarded individuals. Thirty-three of the 99 facilities are attached to hospitals.

Long-term care providers are reimbursed according to an established per diem rate. Medicaid expenditures for long-term care facilities were approximately $50 million in fiscal year 1984-85.

These expenditures account for approximately 51 percent of the total Medicaid benefit expenditures in that time period.

The specific areas we audited and our conclusions or recommendations are described in the following sections.

Patient Assessment System

The patient assessment system is a computerized system used to aide long-term care providers in their care for patients and to provide SRS with information to ensure facilities are fairly compensated for necessary expenses dependent on the amount of care required by the patient. The patient identification numbers on the system should match the patient's Medicaid number on the Montana Income Maintenance System (MIMS). In testing the system we found approximately 13 percent of the patient record numbers on the patient assessment system are not on MIMS. A periodic computer match between the two systems, with the long-term care facilities correcting any errors, would rectify the situation (Recommendation #1, page 19). This would assure SRS all people on the patient assessment system are Medicaid eligible.

The information input to the system is verified on a sample basis by the Montana-Wyoming Foundation for Medical Care (Foundation). The department calculates a facility patient assessment score using the results of the Foundation review. This score could potentially be used in the formula to calculate the facility's annual reimbursement rate. We found the department has not been evaluating the results of the sample using the initial criteria established to pull the sample. Therefore, the department is not always as confident in its results as indicated by the initial criteria. In addition, the department adjusts the results of the sample. This adjustment is not statistically associated with the evaluation technique established under the sampling plan. We recommend the department change its procedures to evaluate the sample results using initial criteria, and eliminate the adjustment procedure (Recommendation #2, page 22).

Intermediate care facilities for the mentally retarded (ICF/MRs) are reimbursed under a different system than other nursing homes. This reimbursement system does not use information from the patient assessment system. Since the information is not used, we recommend SRS not require ICF/MRs to submit patient assessment information for the computer system (Recommendation #3, page 24). This would save the state approximately $2,700 each year, and free up staff for other duties.

Upon the death of a resident, long-term care facilities are to submit information indicating the death. This ensures facilities do not receive management minutes for people after their deaths. Our testing indicates facilities are submitting information in a timely manner and facilities are not recording management minutes after resident deaths (conclusion on page 24).

Monthly staffing reports are used by SRS to determine whether facilities have the appropriate number of staff working each month to provide the care indicated on the patient assessment system. Through actual observation and testing at the facilities we found the information on the reports to be accurate (conclusion on page 26).

Nursing Home Reimbursement System

Nursing home providers are reimbursed according to an established per diem rate. Each nursing home has a rate established at the beginning of the state's fiscal year. (The per diem rate is composed of an operating rate and property rate.) The rate is calculated using a formula which considers such wide ranging factors as required patient care, inflation, and wages in the geographic location of the nursing home.

Several of the components in the operating rate formula contain factors which were created by the department. They include the area wage adjustment, the patient day cost parameter, fixed cost parameter, and patient care adjustment. We could not analyze the reasonableness or initial accuracy of these components

because the Medicaid Bureau does not have any formal documentation of how the components in the operating rate formula were initially arrived at and/or created. Also, an analysis of two of the components showed us the numbers may no longer be representative base figures for calculating the correct adjustment. The lack of documentation and changes in some components resulted in our recommending all components in the formula be rebased and recalculated for future use, and adequate documentation be established (Recommendation #4, page 37).

Our analysis of the property rate formula determined the initial formula and utilization of its components are adequate in terms of documentation and accuracy (conclusion on page 37).

Cost Report Information

During the audit we examined the bureau's review and use of long-term care facility cost reports. We reviewed the department's use of an independent accounting firm to confirm information on specific cost reports, and the timeliness of cost reports submitted by the Department of Institutions.

Our review showed the system is operating adequately. Although cost reports are no longer needed to determine reimbursement to facilities, the reports are supplying the bureau with management information useful in monitoring costs in long-term care facilities (conclusion on page 39). Information gathered by the independent accounting firm is reviewed by SRS and findings are submitted to the audited facilities to allow them to correct any noted deficiencies (conclusion on page 40). No problems were found concerning timeliness of the Department of Institutions submitting cost reports to SRS and monthly claims to the claims processing firm (conclusion on page 41).

Claims Processing

Medicaid claims are processed for payment by a contracted claims processing firm. We reviewed controls over information and the relations the firm has with health care providers.

We noted no significant general data processing control problems which would compromise the integrity of the Medicaid claims processing system. A review of input showed: 1) services are only paid for Medicaid eligible recipients (conclusion on page 43); 2) providers are properly approved prior to payment (conclusion on page 43); 3) reimbursement rates are correct (conclusion on page 44); and 4) information is correctly input (conclusion on page 45).

Four areas of data processing were reviewed. We found payments are calculated correctly and the amounts could be traced to the warrants (conclusion on page 45). We reviewed whether two long-term care facilities could bill for the same person on the same day. We found this problem had occurred, but it has since been resolved by the department (conclusion on page 46). We also found a computer edit was not in place for four months, and for another four months the edit was not functioning correctly. Claims processing personnel did not realize an existing medical procedure had been improperly excluded for payment purposes and department personnel did not do a thorough review of the edit to ensure it was functioning properly. As a result, we recommend the department review edits in the claims processing computer system to ensure all edits are functioning properly and all procedures/services are included (Recommendation #5, page 47).

We wanted to review two management reports for accuracy and timeliness. One report would be used by the department to verify patient day information on cost reports and the other would be used in the settlement process for home health agencies. At the time of our audit SRS had not yet received the reports. The reports are still being developed by the claims processing firm (conclusion on page 47).

During the course of our fieldwork we received complaints from providers concerning the claims processing firm. The two most frequent complaints we received concerned the timeliness of processing claims and lack of information indicating why claims are rejected. Our review showed the vast majority of claims that have

been accepted for microfilming are paid in about two weeks. Included with the reimbursement warrant is a statement of remittance detailing what claims were paid; what claims were denied and why the claims were denied; and claims that are pending payment (conclusion on page 48).

SRS receives reports detailing the reasons claims entered into the system are denied. We found SRS is not using these reports to pinpoint the types of problems that are occurring, and to identify providers having recurring problems. The department should use their reports to identify why some providers are making errors in claims and then use the information to improve provider relations (Recommendation #6, page 51).

Procedures for Ensuring Quality of Care

SRS contracts with the Montana-Wyoming Foundation for Medical Care to: 1) screen people to determine whether they should go into a long-term care facility and at what level of care: skilled, intermediate, or personal; 2) determine whether long-term care Medicaid residents need to stay in the facility and at what level of care; 3) review a sample of resident's nursing records to determine whether information sent to the department is correct; and 4) inspect the care of residents. We determined criteria for each of these activities and reviewed the resulting documentation.

Preadmission screenings must be conducted before a long-term care provider can receive Medicaid reimbursement for care. We sampled a number of patients in long-term care facilities to determine whether screenings were being conducted. We could not find documentation substantiating some screenings but this concern is addressed by the Foundation 1985-86 contract with SRS (conclusion on page 54).

After admission to a long-term care facility, a Medicaid recipient must be reviewed to determine if current care needs are to be continued and at what level. We found that some reviews are not always timely, but were not untimely enough to have any adverse effect. We informed Foundation management of our findings and

they indicated they would stress the timing of the reviews to the nurse coordinators (conclusion on page 55).

Foundation personnel review a sample of forms in long-term care facilities to determine if the information on the forms is substantiated by documentation in each patient's record. The reviewed forms are to be sent to the department by a specified time. We found the abstracts are submitted to the department in a timely manner (conclusion on page 56). Exit conferences are to be held with facility personnel after the Foundation review. We found people consider the exit conferences to be useful (conclusion on page 57). We also found a quality control review is in place to ensure the abstracts are monitored correctly (conclusion on page 58).

The Department of Health and Environmental Sciences (DHES) reviews facilities to ensure they are in compliance with federal regulations and state statutes. At this time DHES personnel also review a sample of residents. Foundation personnel inspect every resident in long-term care facilities to ensure they are receiving adequate care. These reviews are different than Department of Health and Environmental Sciences' surveys so there is no duplication of effort (conclusion on page 59). We found all patients are reviewed (conclusion on page 60), and if alternative placement is indicated, follow-up is conducted (conclusion on page 61). Exit conferences are to be held after the Foundation inspections so facility personnel are made aware of any problems found. We noted exit conferences are not always documented and submitted per guidelines established by SRS. We recommend the department review the documentation for all exit conferences to ensure it is submitted and acceptable (Recommendation #7, page 62).

Bureau Management

During the audit we examined the adequacy of management controls to assure proper direction and attainment of program goals. We found a lack of bureau goals and objectives, and policies and procedures. We recommend the bureau establish long

and short-term goals and objectives; establish formal policies and procedures for the programs it operates; and periodically measure bureau performance to ensure goals and objectives are met (Recommendation #8, page 65).

The bureau annually enters into three contracts: one with an independent accounting firm to conduct on-site audits of specific long-term care facilities; a contract with Blue Cross of Montana to obtain cost information pertaining to home health agencies, hospitals, and nursing homes associated with hospitals; and a contract with the Foundation for preadmission screenings and utilization reviews in long-term care facilities. We found the contracts with the independent accounting firm and Blue Cross are adequately monitored to ensure work is completed to the satisfaction of the bureau and submitted in established time frames.

In examining the monitoring of the Foundation contract for long-term care utilization review, we noted: a) items specified in the contract were not received on time (continued stay reviews and patient abstract monitors) and the SRS staff person handling the contract was not aware; b) one contract provision was not being met (documentation of exit conferences); and c) some information submitted by the Foundation per contract provisions was not reviewed (quality control review results) by the SRS staff person directly responsible for the contract. Because the Foundation provides several important services to SRS, we recommend the bureau actively monitor the contract with the Foundation for utilization reviews of long-term care facilities (Recommendation #9, page 67).

Medicaid recipients in long-term care facilities are reviewed to determine each patient's level of care (skilled, intermediate, or personal) and whether the people should be admitted to, or remain in, the facility. We found there are no guidelines established in a manual for Foundation personnel to use that defines the criteria to be used to determine different levels of care. A manual would help ensure the same criteria is used for all the reviews. We recommend the bureau prioritize staff time so a manual defining

criteria for level of care is developed (Recommendation #10, page 68).

We also examined personnel management within the bureau. We found training was minimal and recommended the bureau develop a formal plan to identify employee training needs and provide necessary training (Recommendation #11, page 68). Employee evaluations and reporting responsibilities were also reviewed and no problems were found (conclusions on pages 69 and 70). At the time we reviewed employee functions the job descriptions outlined the actual functions of bureau staff. Since then functions have changed so bureau management should ensure new job descriptions are written to conform with changes in individual's responsibilities (conclusion on page 69).

Conclusion

During this audit we focused on four major items. We reviewed the rate setting procedure and supporting documentation. We found components of the rate have not been updated since the inception of the rate system and there was little or no documentation to support some numbers. A review of reimbursement procedures showed Medicaid long-term care providers are reimbursed at the amounts established by the department and the majority of reimbursement are timely. Our audit found procedures are in place, and functioning as described, to ensure long-term care Medicaid recipients are receiving adequate care. The last item focused on the administration of the program and we believe the program could be more actively administered and monitored in certain areas.

CHAPTER I

INTRODUCTION

A performance audit of the Department of Social and Rehabilitation Services' (SRS) administration of the Medicaid cost-based services program was requested by the Legislative Audit Committee after a preliminary survey of the Medicaid program was presented to the Committee in 1984. Cost-based services include long-term care, hospital, and home health services.

This report summarizes the result of our performance audit of the long-term care program and its administration by the Medicaid Bureau, Economic Assistance Division. We did not audit the hospital program since SRS had decided prior to our audit to make a major change in the method of reimbursement for hospitals. Any recommendations made pertaining to the old system of reimbursement would have had limited use to SRS. The type of new system, which will be implemented by the Summer of 1986, had already been selected so we could not provide input to a feasibility study. We have completed an audit of the home health services program and our results were presented in a separate audit report.

OBJECTIVES OF AUDIT

The four main objectives of this audit were:

1. To determine if reimbursement rate setting procedures and related standards/rules are reasonable, and supported by documentation.

2. To determine if Medicaid long-term care providers are reimbursed at the amounts established by the department and if reimbursement is in a timely manner.

3. To determine if procedures are in place, and are functioning as described to ensure long-term care Medicaid recipients are receiving adequate care.

4. To determine if the long-term care program and the Medicaid Bureau are being administered in an efficient and effective manner.

In addition, this report is intended to present information on how the Medicaid program is managed by SRS and how the program functions in Montana. We have included this aspect in our report because of the many parties who are concerned with Medicaid.

SCOPE OF AUDIT

The audit was conducted in accordance with generally accepted governmental performance auditing standards. The audit did not include a review of the financial status of the department which is done as a separate audit.

As part of our audit work we reviewed the administrative procedures used by the Medicaid Bureau. We examined bureau management controls such as goals and objectives, policies, and procedures. We also examined personnel management which covered training, evaluation procedures, and staff reporting responsibilities.

During the audit we identified program definitions and requirements to provide criteria for evaluation. We reviewed program expenditures and statistics to determine program status and activity levels.

A number of long-term care facilities were visited to determine if specific documentation pertaining to the on-going evaluation of the need, quality, appropriateness, and timeliness of Medicaid services was present and if selected Medicaid recipients were being cared for in the facilities. We also examined time cards and other long-term care facility records to verify the accuracy of information submitted to SRS. Files pertaining to on-going evaluations of patients were also reviewed at SRS and at the Montana-Wyoming Foundation for Medical Care (Foundation). At SRS we also examined documentation pertaining to the reimbursement system and reviewed a sample of cost reports.

The bureau uses a microcomputer to calculate each facility's yearly reimbursement rate and also to compare yearly changes in specific costs as reported on cost reports. We audited controls pertaining to the microcomputer and the two applications.

The bureau receives information generated by two systems utilizing mainframe computers. One system (patient assessment) maintains information pertaining to Medicaid residents in long-term care facilities. The other system processes Medicaid claims. We audited controls for both systems. We only examined controls pertaining to long-term care facilities in the claims processing system.

During this audit, a new fiscal agent began processing Medicaid claims. Besides reviewing the processing of claims, we also reviewed the effect of this change on provider relations. We had received complaints about timeliness of claim payments and explanations of reasons for denials from a number of different types of providers, so we expanded our scope to review relations of the claims processing firm with all provider types.

During the audit we asked officials at SRS for written responses to selected audit points. These areas related to potential report issues and recommendations, and informed SRS management of issues during the audit, rather than after audit completion.

COMPLIANCE

As part of our audit we reviewed compliance with laws, administrative rules, and policies relating to the long-term care program. We found a number of instances of noncompliance with laws, rules, or policies during our examination. These items are discussed in Chapters VI and VII. For items we did not specifically test for compliance, nothing came to our attention that would indicate significant instances of noncompliance.

REPORT ORGANIZATION

The following chapter describes the overall long-term care program and how it functions. In the remaining chapters we detail our review of the system used to calculate the time needed to care for a patient and how long-term care facilities are reimbursed for this care. We also discuss the use of cost report information to monitor provider costs and identify potential reporting problems.

The processing of claims to reimburse facilities for care provided is discussed in Chapter VI. To ensure people should be placed in long-term care facilities and are receiving adequate care, SRS contracts with the Montana-Wyoming Foundation for Medical Care. Chapter VII details these functions. The final chapters discuss the administration of the Medicaid Bureau, and summarize overall concerns with program administration. Our conclusions and recommendations follow each section.

CHAPTER II

BACKGROUND

Medicaid is an economic assistance program designed to provide medical services to the needy. The program has two major goals: 1) to ensure health care is available to those who otherwise could not afford it, and 2) to improve people's health and thus reduce their dependence on other forms of public aid.

This chapter provides: 1) a brief history of the Medicaid program; 2) an explanation of the long-term care program; 3) an overview of program administration; and 4) statistics on program participants.

HISTORY OF MEDICAID

The Montana Medicaid program was established in 1967 as a federal-state partnership with the federal government providing financial support and basic program guidelines. The Department of Social and Rehabilitation Services (SRS) administers the program, but must establish specific care requirements set forth by the federal government in order for the state to receive matching funds.

With its inception in Montana, only basic services were offered by Medicaid: hospitalization, physicians, skilled nursing home care, prescription drugs, and dental. In 1968, optional services such as intermediate care facilities, medical equipment, and treatment by optometrists and podiatrists were included.

LONG-TERM CARE PROGRAM DESCRIPTION

In December 1985 there were 99 licensed long-term care facilities in Montana receiving Medicaid funds. Ninety-six facilities are nursing homes, including the Center for the Aged and Montana State Hospital (Galen and Warm Springs are considered two facilities.) The Montana Developmental Center at Boulder, Eastmont Human Services Center, and Happy Acres - Ronan, receive

Medicaid funds as intermediate care facilities for mentally retarded individuals. Thirty-three of the 99 facilities are attached to hospitals. Long-term care facilities range in size from 6 to 251 beds.

Long-term care facilities provide skilled, intermediate, and personal care to patients. Medicaid only pays for skilled and intermediate care. Skilled care patients require general medical management and licensed nursing care services on a continuous basis but do not require the constant availability of physician services found only in the hospital setting. Intermediate nursing care patients need some nursing service which is largely routine. The patients' major needs are for light personal care services. Treatment services for intermediate care include: oral medication after routine dosage is established; routine change in dressing to non-infected areas; and routine skin care.

The following illustration details the number of long-term care facilities by level of care provided.

LONG-TERM CARE FACILITIES BY LEVEL OF CARE
As of December 1985

Type of Care Provided	Number of Facilities
Skilled and intermediate care	49
Skilled care only	33
Intermediate care only	12
Intermediate care for mentally retarded	3
Skilled and personal care	1
Skilled, intermediate, and personal care	1
Total	99

Source: Compiled by the Office of the Legislative Auditor from Department of Health and Environmental Sciences' records

Illustration 1

Five types of organizations operate the facilities. Illustration 2 lists the number of facilities operated by each type of organization.

FACILITY OPERATORS
As of December 1985

Type of Operator	Number of Facilities
For profit organization	38
County government	29
Charitable not-for-profit organizations	25
State government	6
Community	1
Total	99

Source: Compiled by the Office of the Legislative Auditor from SRS records

Illustration 2

Provider Requirements to Receive Payments

To receive Medicaid payments for services, long-term care providers must:

1. maintain an appropriate license under the rules of the Department of Health and Environmental Sciences for the category of care being provided;

2. maintain a current Medicaid certification under the rules of SRS for the category of care being provided;

3. maintain a current provider agreement with SRS to provide the care for which payment is being made;

4. employ a licensed nursing home administrator or other qualified supervisor for the facility as statutes or regulations may require;

5. accept, as payment in full for all operating and property costs, the amounts calculated and paid in accordance with the reimbursement method set forth in the ARMs; and

6. insure that any funds maintained in patient trust accounts are used only for those purposes for which the patient, legal guardian, or personal representative of the patient has given written delegation. A provider may not borrow funds from these accounts for any purpose.

The Department of Health and Environmental Sciences (DHES) surveys all long-term care facilities annually to determine whether state criteria are met for licensure. At that time the facility is also reviewed to ensure federal criteria are met for Medicaid certification. DHES reviews such items as:

1. compliance with federal, state, and local laws;
2. governing body and management, including submission of staffing patterns, personnel policies and procedures, staff development, patients' rights, and patient care policies;
3. physician services, including medical findings and physician orders at time of admission, and patient supervision by a physician;
4. nursing services, including patient care plans and administration of drugs;
5. dietetic services, including menus, preparation and service of food, and sanitary conditions;
6. pharmaceutical services, including control and accountability of drugs;
7. social services;
8. medical records, including content, completion, and retention;
9. physical environment, including facilities for the physically handicapped, and maintenance of equipment, building and grounds;
10. infection control, including housekeeping, linen, and pest control;
11. disaster preparedness; and
12. resident accounts.

Long-term care facilities are required to annually enter into a provider agreement (contract) with SRS. The agreement is standard for all facilities and states the provider ". . . agrees to provide to Medicaid-eligible patients all care and services as appropriate which are reimbursable skilled or intermediate care

services within the scope of the Medicaid certification issued to the provider by the Montana Department of Health and Environmental Sciences . . ."

Long-term care providers may not submit claims for an amount in excess of what Medicaid will pay. Some patients do contribute money to their care. In this case, Medicaid pays the balance of the amount billed. Long-term care providers also cannot charge Medicaid patients co-payments.

Preadmission

Prior to providers receiving Medicaid payments for a resident, the resident must be screened by a nurse coordinator to establish the resident's level of care as skilled or intermediate care. The Montana-Wyoming Foundation for Medical Care is under contract with SRS to provide nurse coordinators.

In 23 counties, SRS long-term care specialists also screen Medicaid applicants. The specialists determine whether it is feasible for the applicant to enter into the Medicaid Waiver program, which would provide care at home, instead of entering a nursing home.

Provider Reimbursement

Long-term care providers are reimbursed according to an established per diem rate. (The rate system is discussed in depth in Chapter IV). Each facility has a rate established at the beginning of the state's fiscal year. The 1984-85 fiscal year rates ranged from $27.54 to $73.94 per Medicaid patient per day. Most rates are between $30 and $55. The variations are due to such wide-ranging factors as required patient care, size of facility, and wages in the geographic area where the nursing home is located.

Determination of the reimbursement rate for intermediate care facilities for mentally retarded (ICF/MR) individuals differs from the other long-term care facilities due to the type of patients served. The rate paid for ICF/MRs is based on historical cost data and is limited to an annual 9 percent increase. The fiscal

year 1985-86 rate was increased by 9 percent in all three ICF/MRs. Additional costs are also included in the system to compensate for the special care and services needed for the mentally retarded. Historical cost data is obtained from cost reports that must be submitted annually to SRS by the providers.

Claims Payment

Although SRS establishes the reimbursement rate for long-term care facilities, a private claims processing firm calculates actual provider reimbursement. The firm is responsible for screening and approving provider applications, distributing provider manuals, and processing claims. The firm's claim processing office is in Helena, with computer processing facilities in Atlanta, Georgia. The current fiscal agent assumed responsibility for claims processing March 1, 1985.

To receive reimbursement, long-term care facilities submit a claim (bill) the beginning of each month for services provided the previous month. Service information for each patient is entered into the computer system. The number of days each patient was in the facility is multiplied by the facility's reimbursement rate. The resulting amount, minus the patient's personal contribution for his/her care, is the amount of Medicaid reimbursement for that patient. One warrant is sent to the facility for the aggregate amount of reimbursement for all Medicaid patients in the facility.

An additional duty of the claims processing firm involves provider relations. As a part of this duty, the firm answers questions from providers concerning the status of claims, allowable services, and allowable rates.

ADMINISTRATION OF LONG-TERM CARE PROGRAM

The Economic Assistance Division of the Department of Social and Rehabilitation Services (SRS) is responsible for administering the Medicaid program. The division also administers other assistance programs such as Aid to Families with Dependent Children

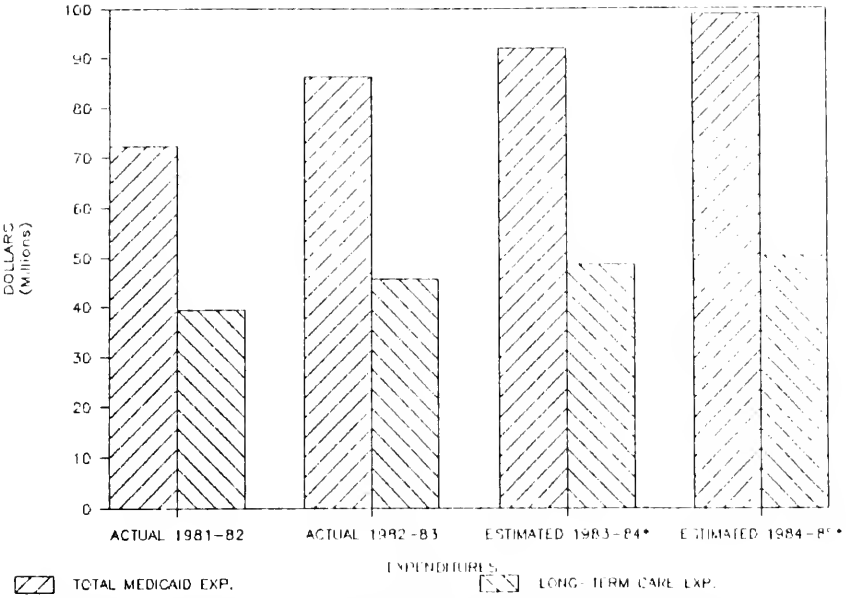
and food stamps. The Medicaid Bureau within the division represents SRS for most matters related to long-term care services. The Medical Financing Bureau administered the program until September 1985, at which time the Financing Bureau and Medicaid Services Bureau were combined to form the Medicaid Bureau. Nine staff members in the bureau are directly responsible for administering the program.

Long-Term Care Program Expenditures

Medicaid expenditures for long-term care services are jointly funded by federal and state governments. The rate of federal financial participation is calculated from a formula using the state's per capita income and the national average per capita income. The federal participation rate for Montana was approximately 64 percent for fiscal year 1984-85.

Expenditures for long-term care services account for approximately 51 percent of the total Medicaid benefit expenditures in fiscal year 1984-85. Illustration 3 shows the total Medicaid benefit expenditures as compared to long-term care service expenditures for fiscal years 1981-82 to 1984-85 (includes both state and federal money). These expenditures do not include Medicaid administration costs.

MEDICAID BENEFIT EXPENDITURES
Fiscal Years 1981-82 Through 1984-85
(In Millions of Dollars)



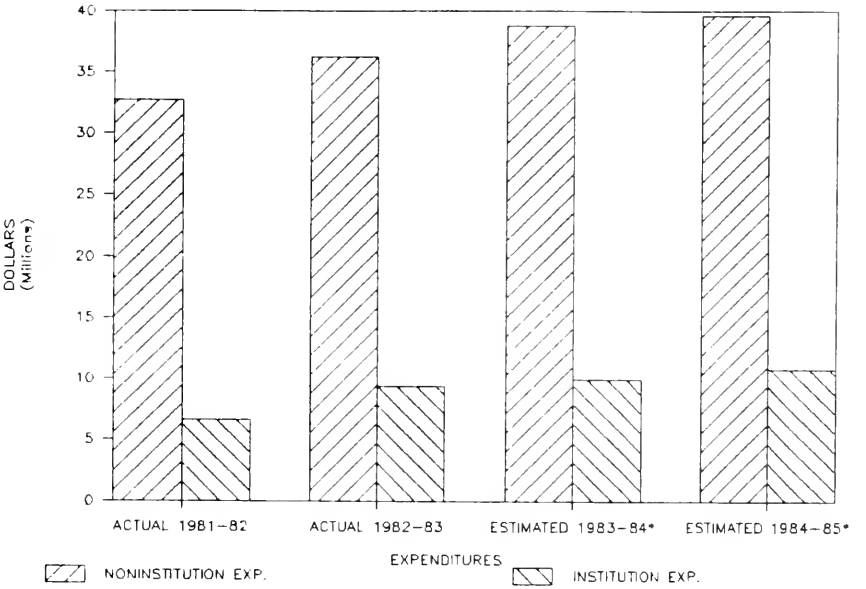
*Not all of the services have been billed yet, so expenditures will increase. The figures in the above illustration are as of November 1985.

Source: Compiled by the Office of the Legislative Auditor from SRS records

Illustration 3

Department of Institutions' facilities for long-term care comprise approximately 20 percent of total Medicaid expenditures for long-term care patients. The following chart compares Medicaid expenditures of the Department of Institutions (DofI) long-term care facilities with non-DofI facilities.

INSTITUTION AND NONINSTITUTION MEDICAID EXPENDITURES
For Fiscal Years 1981-82 Through 1984-85
(In Millions of Dollars)



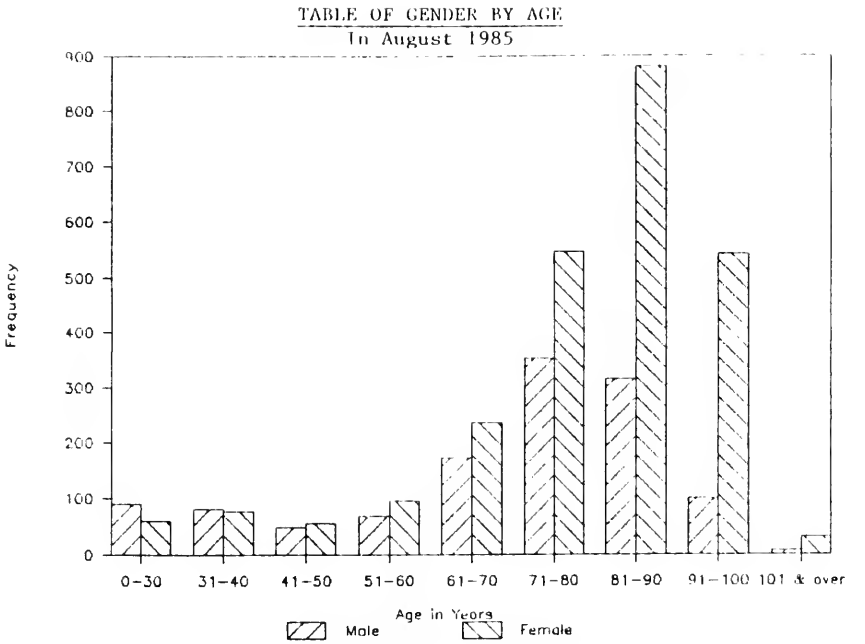
*Not all of the services have been billed yet, so expenditures will increase. The figures in the above illustration are as of November 1985.

Source: Compiled by the Office of the Legislative Auditor from SRS records

Illustration 4

Long-Term Care Facility Resident Statistics

In August 1985, 3,943 people were residents in long-term care facilities. The following table describes age and sex of these residents.



Source: Compiled by the Office of the Legislative Auditor from SRS records

Illustration 5

To determine the types of services provided to long-term care patients, we obtained statistics pertaining to residents' activities of daily living and functional status. Six areas comprise activities of daily living: bathing, dressing, toileting, transferring (from bed to chair, wheelchair, or standing position), eating-feeding, and grooming. Functional status consists of mobility; ability to climb stairs; ability to use the telephone; ability to administer self-medications; ability to shop for oneself; and money management. Each area is categorized as no help needed (resident performs function without assistance); help needed (resident requires some assistance and/or supervision); and unable to do (resident does not participate in activity). We found the majority of residents

are unable to perform many of the functions so facility staff have to perform the functions without help from the resident. The following table illustrates our findings.

FUNCTIONAL STATUS OF RESIDENTS
In August 1985

Function	No Help Needed	Help Needed	Unable to Perform
	%	%	%
Bathing	2	44	54
Dressing	24	32	44
Toileting	38	28	34
Transfer	42	28	30
Eating-Feeding	69	14	17
Grooming	22	34	44
Mobility	22	28	50
Stair Climb	16	19	65
Telephone	14	34	52
Self Medication	1	6	93
Shopping	4	23	73
Money Management	5	21	74

Source: Compiled by the Office of the Legislative Auditor from SRS records

Illustration 6

CHAPTER III

PATIENT ASSESSMENT SYSTEM

The patient assessment system was implemented in Montana in May 1982. The Department of Social and Rehabilitation Services (SRS) adopted the system from Tennessee. The purpose of the system is to determine the amount of nursing time (by calculation of licensed and nonlicensed management minutes) required to provide services and care for residents in a long-term care setting. Licensed time is care provided by licensed personnel (i.e., licensed practical nurses or registered nurses), and nonlicensed time is provided by nursing aides. The result of the information is management minutes for each patient. Management minutes are intended to be a tool for the facilities to help manage staff so adequate care is provided to residents based on the difficulty of care (i.e., the higher the minutes the more time required to care for that resident and the lower the minutes the less time involved). Management minute information is used by SRS to ensure facilities are fairly compensated for necessary expenses dependent upon the amount of care required by the patient.

The patient evaluation abstract form is used to gather the information pertaining to nursing time. This form is completed by long-term care facility personnel upon a person's admission to the facility. Forms are completed only for Medicaid patients and contain specific information concerning the person's condition (whether the person can walk, any bowel and bladder problems, any special treatment needed, etc.).

The form is to be submitted to SRS by the tenth of the month following the patient's admission. Medicaid Bureau personnel review the form for any discrepancies in coding. Discrepancies are resolved by telephone calls to the facility and the resolution noted on the form. Information on the form is then entered into the computerized patient assessment system. Forms are updated as needed by the facility and submitted to SRS.

Facility-wide patient assessment scores are generated by the computer system. These scores are computed using the aggregate management minutes for the facility. The scores are a component in the formula used to determine the facility's Medicaid reimbursement rate. (The formula is discussed on page 32.)

The Medicaid Bureau contracts with the Montana-Wyoming Foundation for Medical Care (Foundation) to monitor facility reporting. Foundation personnel (nurse coordinators) do on-site reviews of documentation at the facilities to assure what is reported to SRS on the abstract is supported by appropriate documentation at the facility. The reviews of a sample of abstracts are done at least twice annually.

During our audit we evaluated various aspects of the patient assessment system including: 1) accuracy of Medicaid identification numbers on the system; 2) SRS evaluation of Foundation patient assessment scores; 3) types of facilities completing forms; 4) facility reporting of residents' deaths so management minutes cease being generated for patients; and 5) facility-wide patient assessment scores generated from information on monthly staffing reports. Our conclusions and recommendations for each of these aspects are included in the following sections.

Accuracy of Patient Record Numbers

The Montana Income Maintenance System (MIMS) contains information on all people eligible for Medicaid. The patient record numbers on the patient assessment system should match the patients' Medicaid numbers on MIMS. For the 12 long-term care facilities we sampled, we found 6 to 10 percent of the patient record numbers were not on MIMS. Because of this we conducted a computer match between MIMS and the patient assessment system for all long-term care facilities. The match showed approximately 13 percent of the patient record numbers on the patient assessment system are not on MIMS.

A number of reasons contribute to the discrepancies. If a person entering a facility has applied for Medicaid but has not

been issued a number, the facility will put the person's room number on the patient abstract form. When the Medicaid number is issued the facility may forget to change the number on the form. We also found long-term care facilities will record the person's Medicare number on the form. Instances of typographical errors were also found.

We estimate as many as 101 of the people identified in our match were not identified as Medicaid eligible in January 1986. If these people are, in actuality, not Medicaid eligible, facilities have been recording inappropriate management minutes. This situation would cause a change in the facility patient assessment score.

Interviews with nurse coordinators indicated they have trouble finding patients when they are given numbers from the patient assessment system and the number is not a Medicaid number.

If SRS would run a computer match between the two systems, the unmatched numbers could be sent to the individual facilities so they know which patient abstract forms are not correct and can correct them. This would assure SRS that people on the patient assessment system are eligible for Medicaid and would help nurse coordinators when they do their reviews. The match would cost SRS approximately $15 for computer time each time it is run.

We believe the match is feasible and would be minimal in time and cost, and would save time for nurse coordinators. When we did the match we allowed for timing differences of numbers getting on the two systems and the use of temporary numbers (identification numbers used until a Medicaid number is issued) by using tapes created in different months (the MIMS tape was a month older than the patient assessment tape; a longer span can be used if it is deemed necessary). If requested, we can provide SRS a copy of the match programs so no SRS staff time would be needed to develop programs.

The first run would be the longest since it would have the most unmatched numbers. Nursing home populations are reasonably stable so subsequent runs would only identify those few patients that had entered the facility since the last run that did not have Medicaid numbers.

RECOMMENDATION #1

WE RECOMMEND THE DEPARTMENT:

A. RUN A PERIODIC COMPUTER MATCH BETWEEN MIMS AND THE PATIENT ASSESSMENT SYSTEM; AND

B. USING THE INFORMATION GENERATED, REQUIRE LONG-TERM CARE FACILITIES TO CORRECT ANY INCORRECT PATIENT RECORD NUMBERS ON THE PATIENT ABSTRACT FORMS.

Evaluation of Results of Foundation Abstract Monitors

As mentioned earlier, the Montana-Wyoming Foundation for Medical Care is under contract with SRS to review a sample of patient evaluation abstract forms submitted to SRS by long-term care facilities. Upon receipt of the monitored abstracts, SRS calculates management minutes for each patient using results from the Foundation review. Two patient assessment scores are then calculated for the facility; one using Foundation management minutes and one using facility-reported management minutes of sampled patients. The Foundation patient assessment score is compared to the facility patient assessment score. If the Foundation and facility scores are not within 10 percent of each other, a letter is sent to the facility explaining it has been deficient in correctly completing patient abstract forms.

The abstracts are monitored because the patient assessment score is used in determining the facility's yearly reimbursement rate. If abstracts are not completed correctly by the facility, the Foundation score will be used in the rate. If there is more than a 10 percent discrepancy between the scores, SRS uses the Foundation's score. If less than a 10 percent discrepancy exists, SRS uses the weighted average of the previous six month's facility-reported scores. (The use of the patient assessment score in the reimbursement rate is discussed in Chapter IV.) The Foundation score used in the rate is adjusted to reflect the entire facility.

Reviewing Sampling Results

A statistical sampling method was developed by SRS to determine how many and which abstracts will be reviewed in each facility. Two criteria were established: the confidence level for sample results was set at 85 percent and the precision of the estimate at 10 percent.

The bureau does not review its sampling results to determine if the initial criteria of 85 percent confidence at plus or minus 10 percent precision is met. Simply using a comparison of plus or minus 10 percent is not giving SRS the statistical confidence specified in the original criteria established to obtain the sample size. The 85 percent confidence level was established to give the bureau an accurate appraisal of how patients should be abstracted. We evaluated 18 facilities' unadjusted Foundation scores and found the plus or minus 10 percent limits around the average score did not always result in 85 percent confidence. The confidence levels for the 18 facilities ranged from 51 to 92 percent. Therefore, SRS is not always as confident in its results for some facilities as indicated by the initial criteria. The underlying cause for the lower confidence appears to be that some sample sizes are too small.

To increase the confidence level and maintain the 10 percent precision, nurse coordinators would have to review more abstracts in each facility since increasing the number of items sampled raises the confidence. The additional number of abstracts to be reviewed would vary for each facility.

One reason sample sizes are lower is because Foundation nurse coordinators are not taking as large a sample as they are instructed. We found approximately 25 percent of the time the sample reviewed by the coordinators was one to three abstracts less than the required sample size. We also found the number used to determine the sample sizes is not consistently rounded up. Rounding the number up would increase sample sizes.

Because the department is not reviewing its sampling results, the department does not know how confident it is the true patient assessment score is in a range of plus or minus 10 percent around

the Foundation score, even though it intended to be 85 percent confident.

To illustrate the effect of using the 85 percent confidence criteria we evaluated 26 facilities' unadjusted Foundation scores using only an 85 percent confidence level. We "dropped" the plus or minus 10 percent precision requirement because in some cases the Foundation sample sizes were not large enough to allow for both criteria to be used together. We found the department rejected facility scores 5 of 26 times when they were within the 85 percent confidence limits. We recalculated the statewide average patient assessment score using these rejected scores (either the unadjusted Foundation score or the weighted average patient assessment scores) and then recalculated the reimbursement rates for the 26 facilities. We found rates in 14 facilities would have increased, 9 would have decreased, and the rates in 3 facilities would have remained the same. For the 26 facilities there would have been approximately $34,000 less paid to the facilities. Since the statewide patient assessment score changed because of the change in individual facility patient assessment scores, the fiscal year 1985-86 rates would have changed in the remaining facilities.

Although evaluating the Foundation scores using only an 85 percent confidence level would directly affect nursing home rates, this method of evaluation cannot be used. Section 46.12.1206(4), ARM, specifies plus or minus 10 percent variance must be used and with current sample sizes this is resulting in lower confidence levels. If the intended statistical analysis (both 85 percent confidence and plus or minus 10 percent precision) is to be used, larger sample sizes are needed.

Adjusted Score

We also reviewed an adjustment the department makes to the Foundation score. After the results of the Foundation review are calculated, SRS adjusts the score to reflect the entire facility. The adjustment consists of obtaining an average ratio of facility scores for the month the nurse coordinators reviewed and the next

month. The Foundation score is then divided by the ratio to obtain an adjusted Foundation score that reflects the score for the entire facility. This method is not statistically associated with the evaluation technique established under the sampling plan used by the Foundation. No adjustment needs to be made to the score since the sampling technique, when evaluated properly, would take into account the entire facility.

Conclusion

The department has established criteria to obtain sample sizes and sample items. It is appropriate the results of the sampling review be evaluated to determine whether the criteria are met. In addition, an adjustment should not be made to the results since the sample obtained would take into account the entire facility.

We informed SRS personnel of our concerns. They responded they would discuss the rounding technique and the number of abstracts reviewed with Foundation management. They also said they would evaluate the adjustment to the Foundation score in relationship to the entire sampling procedure. Budgetary restrictions will have to be considered if the department has to increase sample sizes.

RECOMMENDATION #2

WE RECOMMEND THE DEPARTMENT:

A. EVALUATE SAMPLING RESULTS TO DETERMINE WHETHER CRITERIA ARE MET; AND

B. ELIMINATE THE ADJUSTMENT PROCEDURE.

Patient Abstract Forms for Intermediate Care Facilities for the Mentally Retarded

As noted previously, long-term care facilities are required to complete patient abstract forms for each resident. The form details the management minutes for each patient. The management minutes are then used to develop a patient assessment score. This

score is eventually used in the rate for those facilities reimbursed on a prospective system. Intermediate care facilities for the mentally retarded (ICF/MR) (Montana Developmental Center at Boulder, Eastmont Human Services Center, and Happy Acres - Ronan) are reimbursed on a retrospective basis so the patient assessment score is not used in setting the rate. SRS requires the patient abstract forms to be completed by the ICF/MRs even though the forms are not used by the department. Personnel at SRS estimate it consumes five to six hours a month to review and enter the data for the largest of the three facilities. Another eight hours every six months is spent reviewing the nurse coordinator's monitor of the abstracts at the same facility. Personnel at that facility indicated it takes one person sixteen hours each month to update the abstracts. State personnel spend approximately 275 hours on the patient abstract forms from the two state ICF/MRs.

A sample of the abstracts from the ICF/MRs must also be reviewed by Foundation nurse coordinators. We found approximately 20 hours each year are spent by the coordinators reviewing the abstracts at the two state ICF/MRs.

SRS personnel said they originally intended to set up a reimbursement system for ICF/MRs whereby the patient assessment score from the abstracts would be used. They have not done anything concerning the system, yet are requiring the information to be submitted each month. Information that is time consuming to process and then is not used by the requesting agency should not be required. The state would save approximately $2,700 each year by not requiring this information.

When informed of our finding, department personnel indicated they would cease requiring the information since they do not have staff time to develop the proposed reimbursement system. They expect the development of the system to be labor intensive and do not anticipate initiating this task for some time.

RECOMMENDATION #3

WE RECOMMEND THE DEPARTMENT:

A. STOP REQUIRING INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED TO SUBMIT MONTHLY PATIENT ABSTRACTS; AND

B. NO LONGER REQUIRE FOUNDATION REVIEWS OF THE ABSTRACTS.

Reporting Residents' Deaths

Long-term care facilities are not to be paid for any days of service after a resident dies and should not receive any management minutes applicable to the person. When a resident dies the facility is to submit a patient evaluation abstract form indicating the death. The form is processed and the person is removed from the patient assessment system. To ensure this was happening we compared information on the patient assessment system to information maintained by the Department of Health and Environmental Sciences detailing people who died in the state and the date of death.

Conclusion - We found facilities are removing deceased Medicaid patients from the patient assessment system in a timely manner. We have no concerns facilities are receiving payment or recording management minutes after resident deaths.

Patient Assessment Scores from Staffing Reports

At the beginning of each month, long-term care facilities must submit a staffing report to SRS. This report details the number of hours registered nurses, licensed practical nurses, and aides were on duty during each shift each day of the month. Upon receipt of the staffing reports, Medicaid Bureau personnel determine a patient assessment score for the month from the reports. The total licensed and nonlicensed hours are used in computing the score. The patient assessment score from the staffing report is compared to the patient assessment score used in the reimbursement rate. If the staffing report score is not within 10 percent of

the score used in the reimbursement rate for two months in a row, an audit of facility staffing is to be conducted.

We reviewed documentation to determine whether patient assessment scores from staffing reports are within the designated percent of the score in the rate. We also determined whether audits are conducted. We did not find any instances where the scores were not within the required percent for two months in a row.

To ensure the information submitted on the staffing report was accurate we reviewed time cards for the day of our visit to twelve long-term care facilities. We then computed the registered nurse, licensed practical nurse, and aide time for that day. Our results were compared to the staffing reports submitted to SRS at the end of the month. Our results agreed with the time on the staffing reports.

Copies of Department of Health and Environmental Sciences (DHES) staffing reports are submitted to DHES one week each quarter. These reports detail the type of staff employed and the hours worked for the one week sampled. DHES uses the reports to ensure the facilities are meeting federal standards. If any questions arise, a designated DHES employee calls the facility to determine why the staffing was low.

Since DHES also requires submission of staffing reports we wanted to know if consistent staffing information is submitted and if there is duplication of information and work between DHES and SRS. DHES files were reviewed to determine whether the staffing reports submitted to that department reflect the same information as those sent to SRS and if any follow-up is conducted by DHES of problems found. Our comparison showed nurse's administration time, names of consultants and dates of visits, names and titles of licensed personnel, and number of nursing stations is included in DHES reports. This information is not included, or needed, on SRS staffing reports. The licensed nursing and aide time information on the reports appears consistent.

DHES reviews the reports for different types of information than SRS. DHES staff indicated few staffing problems are noted. If there are problems, they are followed up by telephone calls.

Conclusion - Our review of staffing reports indicated no problems in this area. Scores are within the required percent for two months in a row, indicating facilities have the appropriate number of staff working during the month to provide the care indicated as needed from the patient abstracts. Lack of differences between time cards and staffing reports confirmed information on the staffing reports is accurate.

Since DHES reports are only required one week each quarter, it is not efficient to combine the two forms and require facilities to submit their monthly reports to SRS with all the information needed by DHES. We conclude there is no duplication of effort. Both reports and functions are needed and follow-up is conducted.

CHAPTER IV

NURSING HOME REIMBURSEMENT SYSTEM

We performed a review of the department's system of reimbursing nursing homes which provide care for patients on Medicaid. Nursing home providers are reimbursed according to an established per diem rate. Each nursing home has a rate established at the beginning of the state's fiscal year. The rate is calculated using a formula which considers such wide-ranging factors as required patient care and wages in the geographic area where the nursing home is located. This chapter discusses initiation of the current reimbursement system, explains its usage and modifications since being implemented, and provides an evaluation of the current prospective system.

RETROSPECTIVE TO PROSPECTIVE REIMBURSEMENT

Prior to July 1, 1982, the Department of Social and Rehabilitation Services had a nursing home reimbursement system which was considered retrospective. The system was tied to each facility's historical cost which, in turn, was indexed to produce the upcoming year's reimbursement rate. According to department records, this method rewarded providers who had historically high operating costs with correspondingly high rates, while providers with lower historical costs received rates which were artificially low. Under the retrospective system of reimbursement, the department allowed a settlement process if the providers or the department determined the reimbursement rate did not accurately reflect the provider's expenses. A determination of the final or retrospective rate was made from either a field audit or departmental desk review of the provider's cost report.

In mid-1982 SRS held several administrative rules hearings and informal meetings with providers concerning a department proposal to change the reimbursement methodology from a retrospective to a prospective system. According to the transcript of one of the hearings, the department was motivated to change the

existing system for reimbursing nursing homes for four reasons. The four reasons were:

- federal Medicaid law was changed in a way which allowed the department to reimburse providers on a basis other than the "historical cost related reimbursement" basis.

- the change in federal Medicaid law gave the department the opportunity to re-focus the department's attention away from their traditional role of cost report analysis toward a new role of insuring proper patient care.

- due to less emphasis on cost reports and the need for audits, the department's cost of administering nursing home reimbursement would be reduced.

- for the first time, the department would be able to explain why one facility's rate differed from another facility's.

The department's proposed reimbursement methodology was not tied to each facility's historic costs. Rather, the entire fiscal year 1980-81 cost data from all Montana providers was to be statistically averaged to determine operating rates for each provider. The rates were to be modified by three relative factors: type of facility; level of patient care required; and prevalent wage factors by geographic area.

In order to consider the cost of a facility, a property rate concept was formulated to include a reasonable cost of property. The property rate was to be modified by three factors: type of construction; age of facility; and renovations and additions. The combination of operating and property rates was to be the total rate for a provider. To avoid dramatic and immediate changes in providers' existing rates, the prospective reimbursement system was phased in over a three-year period.

PROSPECTIVE REIMBURSEMENT SYSTEM

The formula for establishing the total reimbursement rate is composed of components which determine the operating and property rates. Within the components there are factors which department officials believe are the most reliable indicators of facilities' overall operating costs.

Operating Rate

The operating rate formula was determined by applying a patient care adjustment and a geographic area wage modifier to a base rate. The formula for determining the base rate for each facility was the result of an examination of cost report information taken from fiscal year 1980-81. The primary variable in determining the base rate is the size of the facility (i.e., the number of beds). The following describes each modifier and the reasons for their inclusion in the operating rate formula.

Patient Care Adjustment Factor - The patient care adjustment factor quantifies the nursing care provided to a patient. The adjustment was included to insure facilities which chose to accept only relatively light care patients were not overpaid for their services, and facilities whose patient mix required a greater expenditure for nursing service time were adequately reimbursed for the additional expense. The patient care adjustment factor is calculated based upon three components: the provider's average nursing care time; the average nursing care time for all providers; and the average nursing care hourly wage.

Area Wage Adjustment Factor - This modifier to the operating rate was included because certain areas of the state pay higher wages than other areas. Department officials believed that to ignore geographic wage differences would unfairly penalize facilities located in areas where labor is inherently more expensive, and to overpay facilities which were located in areas where competent employees could be hired and retained for less.

The area wage adjustment factor is calculated based on two components: the average nursing care hourly wage for a provider's wage area; and the average wage for a provider's wage area. "Wage area" means the geographic area serviced by the Montana Job Service Office in which a provider is located.

Property Rate

In addition to the operating rate, the overall reimbursement rate is affected by the property rate. The property rate is a

calculated rent which, according to department records, originally resulted from an examination of the actual costs-per-bed associated with each free standing facility built in Montana during a ten-year period. Department officials determined the Medicaid program would reimburse property costs on a pro-rated basis. A maximum rate of $6.09 per day per patient was calculated which was based upon 80 percent of the cost of construction of a new facility.

Other Reimbursement Rate Components

There are two other components which affect the reimbursement rate formula: level of occupancy and an inflation factor. Relative to the operating rate compensation, an occupancy of 90 percent has been assumed by department officials. The 90 percent figure was established based upon statewide occupancy studies conducted in fiscal year 1980-81 and from publications such as the State Health Plan which assume the 90 percent to be a reasonable and desirable occupancy rate.

The other component which affects overall reimbursement is the inflation factor. When the prospective system of reimbursement was implemented, both the operating and property rate formulas included inflation factors. The initial operating rate annual inflation factor was 9 percent and the property rate inflation factor was 6 percent. The reason for the difference in inflation factors, according to a department official, was that inflation on building construction was less than general inflation figures. As a result of changing economic conditions, department officials attempted to reduce the operating rate inflation factor; however, a lawsuit by several providers blocked the reduction. The following section on modifications to the prospective reimbursement system will explain the current inflation rate status.

PROSPECTIVE REIMBURSEMENT SYSTEM MODIFICATIONS

Since development and initiation of the prospective system in July of 1982, the three-year phase-in period has been completed and a number of changes to the system have occurred.

Inflation Factor

The earliest and most significant development was the department's attempt to lower the inflation factor used in developing facilities' operating rates. Several providers filed a lawsuit challenging department officials' authority to change the specified inflation factor. The final result was a court-ordered agreement whereby the inflation factor remained at 1.1881 percent for fiscal year 1983-84 and through August of 1984. The factor then changed to 1.1554 for the remainder of fiscal year 1984-85. For fiscal years 1985-86 and 1986-87 the court-ordered agreement specified an operation rate increase which would yield an average industry-wide increase of 4 percent. In addition, the settlement agreement specified there would be no change in the property rate inflation factor from July 1, 1983, through June 30, 1985. Thereafter, the property rate for fiscal years 1985-86 and 1986-87 would be increased by approximately 2.5 percent for each fiscal year.

As a result, department officials do not have any control over the inflation factor used in the operating and property rates for fiscal years 1983-84 through 1986-87. Department officials have indicated a specific inflation factor will not be included in the fiscal year 1987-88 rate formula; rather, the inflation factor may be tied to some generally accepted measure of inflation.

Phase-In Modifications

To avoid dramatic changes in the providers' reimbursement rates when department officials switched from retrospective to prospective reimbursement, a minimum and maximum reimbursement level was established. This reimbursement "band" was initially established at 20 percent (10 percent above and 10 percent below the calculated statewide base rate) so neither high-cost nor low-cost providers obtained substantially different reimbursement rates than they had received in the past. In order to further standardize facilities' reimbursement rates after the phase-in period, department officials reduced the 20 percent reimbursement band to 10 percent for fiscal year 1985-86 and to 5 percent for fiscal year

1986-87. As a result, the base rate minimum and maximum reimbursement limits for fiscal year 1985-86 changed from $24.69 to $26.06 per day for the lower limit of the band and from $30.17 to $28.80 for the upper limit. An average cost facility or a facility constructed after June 30, 1982, would receive $27.43 per day per patient (the calculated statewide base rate).

Part of the compensation provided to facilities is reimbursement for the actual cost of the facility. Property rates were initially determined by paying a flat rate which was then adjusted based upon age of the facility and type of building construction (wood frame or nonwood frame). Useful life and depreciation schedules were determined and an inflation factor established to compute the per diem property rate. As of July 1, 1985, calculation of the property rate was simplified. Department officials eliminated the useful life and construction factors and changed the Administrative Rules so facilities received the higher of the property rates in effect on June 30, 1982 or June 30, 1985. As a result, the maximum rate for a new facility changed from $6.09 to $7.60 per day per patient.

REVIEW OF THE PROSPECTIVE REIMBURSEMENT SYSTEM

The prospective system is based on the concept providers should manage their nursing homes in an efficient and economical manner. The system is composed of an operating and property rate which are developed from data obtained from individual facilities and facilities statewide. The data has been transformed by department officials into mathematical formulas which determine what a facility's reimbursement per day will be. Our review of the reimbursement system involved analysis of the adequacy and accuracy of formula components.

Operating Rate

The following is a mathematical description of the operating rate in effect for fiscal year 1985-86.

$A=Bx[(C\div.9)x(28.80+(54,627\div(D)))+E]$

A = Dollars per patient day
B = Area wage adjustment
C = Inflation factor
D = 366 days x the number of licensed beds in a facility
E = Patient care adjustment
.9 = Occupancy level
$28.80 = Patient day cost parameter
$54,627 = Fixed cost parameter

As shown, the operating rate consists of a number of independent components which in turn require mathematical calculations to arrive at the final answer. Several of these components contain factors which were created by department officials. They include the area wage adjustment, the patient day cost parameter, fixed cost parameter, and patient assessment score. We examined each of the components and factors to determine whether they adequately and accurately reflect what department officials intended.

Area Wage Adjustment

Within the area wage adjustment component, department officials use a numerical factor of .71 to signify the percentage of a facility's total operating costs spent to compensate a facility's employees. In other words, department officials determined that 71 percent of a facility's operating costs are a result of labor costs. According to department officials, the function of the factor is to minimize the impact of the area wage adjustment component to what it would only be for labor costs, rather than considering all operating costs. Our review of the factor revealed two problems. First, department officials could not provide documentation of how the .71 was initially calculated. Secondly, when we recalculated the percentage of operating costs attributable to labor for fiscal year 1982-83, labor costs were approximately 10 percent less than the .71 used by department officials in fiscal year 1981-82. The changing costs of labor as a percentage of total operating costs has not been considered on a periodic basis.

Patient Day and Fixed Cost Parameters

The patient day and fixed cost parameter components represent the historical portions of the operating rate. The patient day cost parameter is varied depending upon the operating rate the facility received in 1982. As previously noted, department officials instituted a reimbursement band in order to avoid dramatic changes in a facility's level of reimbursement when the reimbursement system was changed from retrospective to prospective. As a result, the patient day cost parameter can be $26.06, $27.43, or $28.80. The parameter, according to department officials, represents the minimum variable cost per patient per day for a facility to provide adequate care to a patient as of June 30, 1982.

During our review, department officials could not provide adequate documentation concerning how the patient day cost parameters were initially determined, or whether the figures accurately portrayed facility costs per patient. A former department official attempted to re-create the patient day cost parameter in May of 1983. At that time he could not determine the origins of the $27.43 base rate figure, and he also believed the base rate figure (which is still being used) should have been at least 60 cents per day less. Currently, it is not possible to determine from department records either how the parameter was created or what the correct figure(s) should be.

The fixed cost parameter constitutes the second historical factor in the operating rate. Department officials stated the numerical component of $54,627 represents the minimum dollar amount a facility required to become operational on June 30, 1982. The fixed operating cost figure was based on a department-computed regression analysis which used prior nursing home cost reports. Our review of department-provided data could not provide adequate assurance the $54,627 accurately represents the actual fixed cost of operating a facility as of June 30, 1982. Also, the department's internal examination of the reimbursement formula could not re-create the fixed cost figure. The department official's review of the department calculations indicated the fixed cost parameter

could be over $61,000 in one case and as little as $17,250 in another. However, the official was not able to find supporting documentation for the current figure used.

Patient Care Adjustment

The patient care adjustment component contains a factor which helps establish a facility's patient assessment score (see Chapter III for a description of the patient assessment system). Within the formula for determining the patient assessment score there is a ratio figure (1.699) which converts licensed nursing hours to non-licensed hours. (Nonlicensed hours are used because the majority of care given to patients is by nursing aides rather than licensed nurses). The purpose of the ratio is to provide a standardized measure of the total number of nursing hours required for the patients in a facility. The 1.699 ratio was developed in 1982 from a facility wage survey. The ratio has not been updated since, even though wages have changed. In addition, a departmental examination of how the patient care adjustment factor was created revealed the initial calculation of the 1.699 ratio did not consider licensed practical nursing wages, only the wages of registered nurses were considered. As a result, the ratio may not accurately reflect all licensed nursing hours.

Conclusion

We reviewed the formula used to determine the Medicaid reimbursement for nursing homes. The formula is made up of several components which determine how much compensation the nursing homes should receive per patient, per day. The formula components include but are not limited to: an area wage adjustment, a patient day cost parameter, a fixed cost parameter, and a patient care adjustment. The information derived from the components in the formula provide the basis for SRS to expend over $50 million (fiscal year 1984-85) on nursing homes which provide services to Medicaid patients.

During our review, we could not analyze the reasonableness or initial accuracy of several formula components because the Medicaid Bureau does not have any formal documentation of how the components were created and/or initially arrived at. For example, the patient day and fixed cost parameters constitute a significant portion of the total reimbursement rate a nursing home receives, yet department personnel could provide neither a satisfactory verbal nor written explanation of how the parameters were created or calculated. In addition, our examination revealed numerical figures in the area wage adjustment and patient care adjustment components (.71 and 1.699, respectively) may no longer be accurate base figures for calculating the correct adjustment for the two components. Also, the components have not been updated since their development in 1982, even though there has been changes in employee wages and benefits.

The undocumented components preclude SRS and outside sources from reviewing the reimbursement formula for reasonableness, accuracy, and timeliness. As a result, it is not possible to determine whether department officials are using the correct or most up-to-date base figures in the formula or whether the nursing homes are receiving the intended amount of reimbursement. In addition, the lack of documentation makes it difficult for department officials to justify and/or explain the reimbursement formula to either new employees or outside sources. Interviews with department officials indicate the current reimbursement formula was in place before current management was in place and previous management did not document their creation of the formula.

Since department officials cannot provide formal documentation of how the reimbursement formula was developed and calculated, we recommend all components in the formula be rebased and recalculated for future use. Development of updated components should be fully documented so SRS, nursing homes, and outside sources can review the reasonableness and accuracy of the base components. In addition, all the formula components should be periodically reviewed and updated as economic and other conditions change.

RECOMMENDATION #4

WE RECOMMEND THE DEPARTMENT REVIEW ALL THE COMPONENTS IN THE REIMBURSEMENT FORMULA AND:

A. REBASE AND RECALCULATE ALL COMPONENTS IN THE OPERATING RATE FOR FUTURE USE;

B. COMPLETELY DOCUMENT REIMBURSEMENT FORMULA DEVELOPMENT AND CHANGES; AND

C. PERIODICALLY REVIEW AND UPDATE FORMULA COMPONENTS.

Property Rate

The second portion of the prospective reimbursement system is the property rate. This is reimbursement for costs associated with operating and maintaining a facility. The rate is historically based on the age and type of facility. The following is a narrative mathematical description of the property rate in effect for fiscal year 1985-86.

Property Rate=
(The larger of the interim property rate in effect on June 30, 1982) or (the formula property rate in effect on June 30, 1985 x the inflation factor)

Conclusion - Our analysis of the property rate determined the initial formulation and utilization of its components are adequate in terms of documentation and accuracy. The changes made for fiscal year 1985-86 are a simplification of the previous property rate format.

CHAPTER V

COST REPORT INFORMATION

During our audit we examined the bureau review and use of cost reports. Our objectives were to determine if the information on the cost reports is used and how; if the review and use conforms to the current reimbursement methodology; and whether cost reports are needed. We reviewed the department's use of an independent accounting firm to confirm information on specific cost reports, and the timeliness of cost reports submitted by the Department of Institutions. These areas are discussed below.

REVIEW OF COST REPORTS

Each year all long-term care providers must submit a detailed cost report to the Medicaid Bureau. Cost reports contain such information as: 1) patient census; 2) revenue received from Medicare, Medicaid, and private pay; 3) ancillary revenues; 4) property costs; and 5) cost allocations to operation of plant, dietary, nursing administration, office administration and general.

On July 1, 1982, the method of reimbursement to long-term care providers changed from an interim rate with year-end adjustments to a prospective rate. This change caused bureau staff to focus their attention on different aspects of cost reports submitted after June 30, 1982. Instead of using the reports to make year-end adjustments, variances in specific costs between years are examined and costs of individual facilities are compared to industry average costs.

Cost reports for 33 long-term care facilities associated with hospitals are reviewed by Blue Cross of Montana in Great Falls instead of SRS. These providers submit one cost report to SRS which sends it to Blue Cross after the report is recorded as received.

A fiscal year 1984-85 agreement with Blue Cross states the cost report review will take into consideration the different emphasis SRS is placing on cost reports. Blue Cross will continue to

review these facilities' cost reports as long as Medicare remains on a cost-based system for nursing homes. Having Blue Cross review the cost reports avoids duplication of SRS and Blue Cross both reviewing reports for those facilities attached to hospitals.

During our audit we examined Blue Cross procedures in reviewing cost reports to determine whether they are consistent with SRS procedures. We also reviewed for the adequacy of both procedures. We found the two procedures are comparable and the same areas are reviewed or audited. Both procedures are adequate for verifying and analyzing the information on the reports. Also, Blue Cross reviews or audits comply with contract provisions.

Conclusion - Although cost reports are no longer needed to determine reimbursement to facilities, the reports supply the bureau with management information useful in monitoring costs in long-term care facilities. Variances are determined and significant changes can be investigated for possible problems. As of September 1985 no variances had been investigated.

CONTRACT WITH INDEPENDENT ACCOUNTING FIRM

Annually, SRS contracts with an independent accounting firm to review a select number of cost reports from facilities not associated with hospitals. The contract issued in 1985 changed the emphasis of items to be reviewed since the cost reports audited are under the new rate system. Twenty-five audits, ten full-scope and fifteen limited-scope, are scheduled under the contract. A full-scope audit of the provider cost report includes an examination of financial transactions, accounts, and reports, including an evaluation of compliance with applicable Administration Rules of Montana. A limited-scope audit examines the staffing reports and a selected part of each provider's Medicaid cost report and related financial records, including patient census, and patient trust areas.

We examined this area to determine whether the work to be completed under the 1985 contract is consistent with the new

emphasis on cost reports. We also wanted to know if SRS personnel review the workpapers and use the information contained in the audits.

Conclusion - The request for proposal for the 1985 contract confirmed SRS is having the firm review reports for the same types of items reviewed by bureau staff. An examination of the workpapers showed that bureau staff review the papers and submit their findings to the respective facilities.

DEPARTMENT OF INSTITUTIONS REIMBURSEMENT

During our audit, the Department of Institutions (Dofl) had five facilities which were involved in the Medicaid program. These were: the Montana Developmental Center at Boulder, Eastmont Human Services Center, Galen, Warm Springs, and the Center for the Aged. Due to differing services provided, there are two classifications for the institutions - two are classified as intermediate care facilities for the mentally retarded (Boulder and Eastmont), and the remaining three are intermediate care facilities. Facilities for the mentally retarded are reimbursed on a retrospective basis, with adjustments made after cost reports are filed; the other facilities are reimbursed using the same formula as nursing homes.

The retrospective method is similar to the system used prior to June 30, 1982. The rate paid is based on historical cost data and is limited to an annual 9 percent increase. The fiscal year 1985-86 rate was increased by 9 percent in all three ICF/MRs. Additional costs are also included in the system to compensate for the special care and services needed for the mentally retarded. Historical cost data is obtained from the annual cost reports submitted to the Medicaid Bureau.

We reviewed documentation to determine whether Dofl is submitting cost reports and monthly claims in a timely manner. If cost reports are not submitted in established time frames, SRS can assess penalties. Dofl can offset these penalties with General Fund money (the money would be reimbursed to the Fund when the

cost reports were submitted). The General Fund is also impacted if monthly claims are not submitted in a timely manner.

Conclusion - During our audit we reviewed the timeliness of submitting cost reports and monthly bills, and the cost data used to establish the reimbursement rate. We found DofI is submitting cost reports in a timely manner so SRS is not required to assess any penalties. Because reports are submitted in prescribed time limits, the most current data is used to establish the reimbursement rate. We also found monthly billings are occurring in a timely manner, and because of the flow of funds between SRS, DofI, and Federal reimbursement, there is no impact on the General Fund.

CHAPTER VI

CLAIMS PROCESSING

On March 1, 1985, the firm processing claims for Medicaid payments changed. Prior to March, claims were sent to Great Falls for entry into a computer system located in Albuquerque, New Mexico. The current claims processing firm enters claims information in Helena for processing in a computer system located in Atlanta, Georgia.

During our audit we examined general controls over processing. General controls include: 1) adequate physical environment (fire, water, and power protection; temperature and humidity controls) and security (distribution of keys and combinations); 2) access to computer programs and data files; and 3) computer systems development and maintenance. We noted no significant general control problems which would compromise the integrity of the Medicaid claims processing system.

We also examined application controls for long-term care facilities and home health agencies. Application controls include approval of providers for payment, correct input of reimbursement rates, correct calculation of payments, and reviewing edits to ensure they are functioning correctly.

Visits to long-term care and home health agency providers indicated there are problems with the timeliness of claims processing and providers do not know why claims are being rejected. Since these are areas applicable to all types of providers we examined these problems for all providers.

Our findings are discussed in the following sections.

INPUT CONTROLS

We reviewed four major input areas. The four areas included:

1. recipient eligibility;
2. approval of providers;
3. whether reimbursement rates are correct; and
4. whether information is input correctly.

Recipient Eligibility

Only people eligible for Medicaid are to have services paid by Medicaid. A sample of 200 people that had received services paid by Medicaid since March 1, 1985, was taken. We then reviewed the Montana Income Maintenance System (MIMS) to determine whether the people were eligible for Medicaid on the date the service was performed. MIMS is a computer system that tracks, among other assistance programs, Medicaid eligible people.

Conclusion - Our review showed all 200 people were eligible for Medicaid the day the service was provided. We can conclude Medicaid pays for services for only those people who are Medicaid eligible.

Approval of Long-Term Care Providers

For a provider to be reimbursed by Medicaid, it must submit an application for a provider number to the claims processing firm. Before the application is approved the firm contacts the Medicaid Bureau to confirm SRS has the proper paperwork (current contract and the Department of Health and Environmental Sciences has completed a survey and licensed the provider). If all the paperwork is present, SRS will notify the claims processing firm of the proper reimbursement rate. The firm then sends the provider a provider number and puts the necessary information in the computer system. This process is repeated annually.

We examined procedures to determine whether the process is functioning as it was described to us.

Conclusion - Our review indicated the necessary paperwork is at the claims processing firm and SRS. Providers are correctly approved for reimbursement.

Correct Reimbursement Rates

Long-term care facilities and home health agencies are reimbursed at an established rate. As described previously, long-term care facilities receive a specified amount per Medicaid patient day.

Home health agencies are paid a specified amount per type of service. Medical supplies provided by the agencies are to be reimbursed at 100 percent of the cost to the agency. The rates are communicated by SRS to the claims processing firm which enters them into the computer system.

Our review showed long-term care facilities and home health agencies rates were correctly input to the computer system. There were problems with the reimbursement of medical supplies to home health agencies. The rate was initially set at a percentage less than 100 percent of cost. In August 1985, the department discovered the error and communicated the problem to the claims processing firm. Correction of the error was prioritized with other programming requests. In February 1986 it was corrected. Any money not received by home health agencies in the eleven-month period since March 1 will be reimbursed to them at the end of the agencies' fiscal year when final settlements are determined. The error was not a higher priority and corrected earlier because a compensating control (the year-end settlement process) exists for home health agencies.

Conclusion - With correction of the error, we can conclude the long-term care facilities and home health agencies rates are correctly input to the computer system.

Information Input Correctly

As claims are submitted to the claims processing firm, they are key entered into the computer system. The key entry operators (examiners) must enter the information on the claim. The information entered is not key verified by another person at the time of entry. A number of edits in the computer system will identify some errors (numbers are where numbers should be, recipients are eligible, provider numbers are valid, etc.).

Each week a sample of 40 claims entered by each examiner is reviewed by the firm's quality control personnel. The original claim is compared to the information in the computer system. Any key entry errors are noted and corrected.

A sample of 720 claims were examined to determine if the information was correctly input. We found seven claims (less than 1 percent) had an error made by the claims processing firm. Five of the errors could possibly cause an incorrect or delay of payment. One of the five will cause an overpayment of $64 if the error is not caught.

Conclusion - As with any system there will be human errors. The number of such errors is decreased by the quality control review conducted by the claims processing firm. We believe controls are adequate to provide reasonable assurance information is correctly input.

PROCESSING CONTROLS

Four areas of processing controls were reviewed. These areas were:

1. calculation of payments and warrant amounts;
2. a determination that two nursing homes are not billing Medicaid for the same person for the same day;
3. home health agency limitation edit of $400 per month per recipient; and
4. accuracy and timeliness of management reports.

Calculation of Payments

Long-term care facilities are paid for the total number of days Medicaid residents are in the facility for each month. The number of days, times the reimbursement rate, minus the personal contributions, or other insurance, is the total reimbursed to the facility. The total amount of the claim should be traceable to the warrant sent to the facility for that month's reimbursement.

Conclusion - To determine whether payments are correctly calculated, we recalculated a sample of payments and found no problems. The computer programming was correctly calculating payments. The total amount of the claim was traced to the warrant register with no problems noted.

Double Billing for Same Person

A long-term care facility can bill Medicaid for the day a person enters the facility but not for the day discharged. If a person transfers from one facility to another on the same day, only one facility is supposed to bill and be paid for the person.

If a person transfers from a long-term care facility to a hospital as an in-patient, both could potentially submit bills for the same day. In this case, documentation should be submitted to SRS by the long-term care facility indicating it needs to hold the bed while the person is in the hospital.

We examined a sample of claims to ensure a control was in place so only one provider was being paid for each day, or, if two were paid, required documentation was present.

Conclusion - We examined 145 claims and found 24 cases where a person transferred from one long-term care facility to another or to a hospital. In two of the 24 transfers, both long-term care facilities billed and were paid for the person for the same day. We brought this to the attention of personnel at SRS and the claims processing firm. They rectified the problem so only the admitting facility will be paid for the person.

No concerns were noted pertaining to people transferring to hospitals from long-term care facilities.

Home Health Limitations

Administrative Rules of Montana state expenditures for home health services over $400 per recipient, per month, must be prior authorized by SRS officials. If the authorization is not present on, or with the claim, the claims processing firm is not to pay the amount billed. An edit in the computer system is supposed to flag the claim. The claim is then sent to SRS, where personnel decide how much of the claim should be paid (the full amount, just $400, or some intermediate amount). The claim is then returned to the claims processing firm and the indicated amount paid.

We found the edit to identify home health agency claims for expenditures over $400 per recipient per month was not in the

computer system until July 3, 1985, four months after the firm started processing claims. In November 1985 we found that even though the edit was in place it was not functioning properly. A service provided by the agencies was not included in the edit. As a result, $2,671 was paid to home health agencies between July 3, 1985, and November 12, 1985, that was not authorized by SRS. Claims processing personnel did not realize the particular procedure excluded existed.

RECOMMENDATION #5

WE RECOMMEND THE DEPARTMENT REVIEW EDITS IN THE CLAIMS PROCESSING COMPUTER SYSTEM TO ENSURE THEY ARE FUNCTIONING PROPERLY AND ALL PROCEDURES/SERVICES ARE INCLUDED.

Management Reports

Management reports are to be received by SRS from the claims processing firm. One of these reports will be used to verify patient day information on long-term care cost reports, and another will be used in the settlement process for home health agencies.

At the time of our audit the bureau had not yet received these two management reports so we could not determine whether they are accurate and received in a timely manner. The reports are still being developed by the claims processing firms. SRS personnel have reviewed a number of examples of the reports and have not yet accepted them since they are not adequate for their needs. No payment has been made to the firm for the reports.

Conclusion - Management information at this time is limited. Some processes cannot be adequately performed by SRS personnel.

PROVIDER RELATIONS

During the course of our fieldwork we received complaints from providers concerning the claims processing firm. We reviewed provider relations with the firm to determine the types of

complaints and whether the firm was addressing them. We also looked at the number of claims denied and the reasons for denial. The following sections discuss our findings.

Provider Complaints

The two most frequent complaints we received concerned the timeliness of processing claims and lack of information indicating why claims are rejected. We found correctly completed claims are being paid in a timely manner. Once the claims are accepted for microfilming it only takes about two weeks for the claim to be processed and paid. The claims processing firm does not maintain documentation that would indicate why a claim would not be accepted for microfilming.

We also found the claims processing firm includes a statement of remittance to each provider with each warrant sent. The statement details what claims were paid; what claims were denied, the amount denied, and why the claim was denied; and claims that are pending payment. This statement of remittance indicates providers are being informed why claims are denied.

Conclusion - Our review indicated claims are being paid within two weeks of the time they are accepted for microfilming. This appears to be a reasonable time period.

Denied claims are identified on a statement sent to providers. The statement explains the reason for denial in a straight-forward manner.

Number of Claims and Reasons for Denials

We also looked at the number of claims denied and the reasons for denial to determine if a large number are being denied. We also determined whether the reasons for denial are the fault of the provider or SRS.

SRS receives monthly reports detailing the total number of claims processed, paid, and denied. We reviewed these reports for four different months. The following table details the number

of claims processed and the number denied in each of the sampled months.

CLAIMS PROCESSED AND DENIED

Month	Number Processed	Number Denied	Percent Denied
May 1985	76,153	16,064	21.09
August 1985	90,353	20,126	22.27
October 1985	76,734	11,321	14.75
November 1985	60,688	10,782	17.77

Source: MARS report

Illustration 7

SRS also receives monthly reports that list for each provider the number of claims submitted, the number paid, the number denied, and the reasons for denials. This information is summarized by the types of providers (nursing homes, drugs, inpatient, outpatient lab, dental, miscellaneous, etc.). The ten most common reasons for denials, and the number of times that reason occurred, are also summarized by type of provider.

The reasons for denials vary. Some can be attributed to provider error and some to SRS for not updating information. Illustration 8 details the types of denial reasons that occurred most frequently and the percentage of times the reason occurred.

MOST COMMON REASONS FOR DENIAL OF CLAIMS

Reason	Percent in each Month			
	May 1985	August 1985	October 1985	November 1985
Potential duplicate claim	8.22	14.11	16.35	20.15
Claim more than 180 days old (provider needs to attach specific slip to get claim processed)	6.90	4.50	13.30	12.50
Provider needs to include provider number	6.90	11.70	0.00	1.14
Provider needs to include recipient number	0.00	6.40	0.98	1.60
SRS needs to complete necessary paperwork to get person on eligibility file	15.57	12.50	20.60	20.80
Provider needs to bill recipient's insurance company prior to receiving Medicaid payments	7.90	8.77	10.40	9.80
Prior authorization required	1.30	2.30	1.90	3.00
Recipient not eligible for dates of service	8.60	7.11	8.82	9.29
Type of service/procedure/drug code not on file	21.00	18.17	9.00	6.74
Provider not eligible/ terminated from program	6.26	2.67	2.90	2.60

Source: Compiled by the Office of the Legislative Auditor from SRS records

Illustration 8

The list represents over 80 percent of the reasons for denials in each month. Each of the remaining categories (there were over 70 reasons listed in the four months) had less than 3 percent of the errors attributed to them.

The reports are a valuable source of management information. They can be used to pinpoint the types of problems that are occurring, and identify providers having recurring problems. SRS is presently not using this information to help answer provider complaints. Officials indicated they do not have the staff time to look at the reports. However, we found time would be minimal to review the reports and identify the reasons for denials.

RECOMMENDATION #6

WE RECOMMEND THE DEPARTMENT:

A. USE THE DENIAL REPORTS TO DETERMINE WHY PROVIDERS ARE MAKING ERRORS IN CLAIMS; AND

B. USE THE INFORMATION TO IMPROVE PROVIDER RELATIONS.

CHAPTER VII

PROCEDURES FOR ENSURING QUALITY OF CARE

The Department of Social and Rehabilitation Services (SRS) enters into annual contracts with the Montana-Wyoming Foundation for Medical Care (Foundation). The contracts state the Foundation is to provide the following activities for skilled nursing facilities; intermediate care facilities; institutions for mental diseases; and intermediate care facilities for the mentally retarded:

1. preadmission screening;
2. continued stay reviews;
3. abstract monitors; and
4. inspections of care.

We determined criteria for each of these activities and reviewed the resulting documentation. A description of each function and our conclusions and recommendations are discussed in the following sections.

PREADMISSION SCREENING OF LONG-TERM CARE PATIENTS

Prior to admission to a long-term care facility, a Medicaid eligible applicant must be screened. People already in long-term care facilities applying for Medicaid benefits must also be screened before the facility can receive the initial Medicaid payment. The screening team consists of a nurse coordinator from the Foundation and a long-term care specialist employed by SRS.

The nurse coordinator reviews the applicant to determine what type of care is needed; whether the person should be admitted to a long-term care facility (and at what level of care, skilled, intermediate, or personal) or is eligible for services in the home and community-based (waiver) program. The nurse coordinator uses the patient evaluation abstract form discussed in Chapter III to determine the level of care required. To be eligible for long-term care Medicaid benefits, a person must require skilled or intermediate care.

There is no specific number of management minutes required for a person to be considered appropriate for long-term care since the type of care needed and alternatives to long-term care must be considered. For example, a person requiring physical therapy may require a large number of management minutes but the waiver program is in the area so a person may not need to enter a long-term care facility. Another person may not require as many management minutes, but because other alternatives are not available, the person may have to enter a long-term care facility.

Long-term care specialists use a geriatric functional rating scale form to evaluate the applicant's social and psychological functions. The specialists score the person's physical condition (eyesight, hearing, mobility, diet, etc.); mental condition; functional abilities; support from the community (availability and accessibility of facilities); financial situation, etc. Again, there is no cutoff score to determine whether an applicant should enter a long-term care facility or be on the waiver program. If the results of the two forms differ, the findings from the abstract form are usually weighted heavier in the final decision.

Not all counties are covered by long-term care specialists. Applicants in those counties not covered (23 total) are only screened by the nurse coordinator. These same counties also are not in the waiver program so the applicant would only be screened for admission into a long-term care facility and eligibility for Medicaid benefits.

We sampled a number of patients in long-term care facilities to determine whether they had been screened prior to admission, or prior to receiving Medicaid benefits if already in the facility, per requirements in the Administrative Rules of Montana. We also determined whether providers receive Medicaid reimbursement for a patient before the patient is screened.

Twenty of our sample of 112 patients had entered facilities since February 1983 when the present screening system (use of both forms) started. We could not find any documentation indicating these 20 had been screened. Department personnel indicated

specific documentation requirements for people entering long-term care facilities had not been established for use by nurse coordinators and long-term care specialists so some documentation might not be available. Procedures detailed in the 1985-86 contract with the Foundation require better documentation of screenings and its retention.

In reviewing information pertaining to payments to providers, we found an edit in the claims processing system will not allow a Medicaid payment to be made to a facility until documentation is sent to SRS indicating a screening took place. We found the edit is in place and functioning.

Conclusion - Long-term care applicants or residents are supposed to be prescreened prior to the provider receiving Medicaid reimbursement for the person. During our review we could not find documentation substantiating some screenings. Requirements in the 1985-86 contract with the Foundation alleviate our concern pertaining to documentation of screenings. An edit in the claims processing system ensures Medicaid payments are not made until the applicant is screened for admission to the Medicaid program.

CONTINUED STAY REVIEWS

After admission to a long-term care facility, the nurse coordinator assigns initial and subsequent continued stay review dates. During the review the nurse coordinator determines whether the level of care the patient is assigned is correct. Review dates assigned depend on level of care the patient is receiving. Skilled care patients must be reviewed at least every 90 days and intermediate care patients must be reviewed at least every six months. The review dates are to be recorded in the patient's nursing record. The nurse coordinator is also supposed to maintain a log showing dates and level of care for each patient. At the end of the month an updated log is to be sent to the Foundation.

The logs maintained in the long-term care facilities were requested so we could determine whether residents are reviewed in the specified time periods. We found the logs to be maintained in

the patient's records could not always be located. This was primarily the fault of the facility since personnel would take the sheet out of the record. Nurse coordinators indicated they also have problems finding the logs. We also found the logs maintained by the nurse coordinators in the patient's records did not reconcile to the logs sent to the Foundation.

The problems with the logs were alleviated with a new procedure implemented in November 1985 by the Foundation. During continued stay reviews nurse coordinators are now filling out a three-part copy form. The original copy is sent to the Foundation, the second copy maintained in the patient's medical record, and the third retained by the coordinator.

We also found the majority of reviews are not completed within the time limits specified in the contract between SRS and the Foundation. Of 113 patients sampled, 83 were not reviewed within the prescribed time limits. Twenty-one of the eighty-three were reviewed in seven months instead of six months. We could not find any documentation since late 1983 or early 1984 for 47. As noted above, this last problem was alleviated with the new documentation requirements.

Conclusion - Although the reviews are not always timely, there does not appear to be any adverse effect. All the records of people we sampled indicated a need to remain in a long-term care facility. Bureau personnel indicated federal reviewers have never examined continued stay reviews. It does not appear any monetary sanctions would be imposed because federal regulations are not being followed explicitly. We informed Foundation management of our findings and they indicated they would stress the timing of the reviews to the nurse coordinators.

ABSTRACT MONITORS

As discussed in Chapter III, the Foundation reviews a sample of each long-term care facility's patient assessment abstracts twice yearly. The reviews are done to determine if the information on

the abstract forms sent to SRS is substantiated by documentation in each patient's record. If supporting documentation is not in the records nurse coordinators will make changes to their copy of the abstract form so it agrees with documentation in the patient's record. An exit interview with the provider is conducted at the end of the review. During this interview coordinators explain any changes made to the abstracts and why they made the changes. They will also discuss any documentation problems in the medical records they noted. The patient abstracts reviewed and a copy of the exit interview are then sent to SRS.

We reviewed three areas pertaining to the abstract monitors: 1) the timeliness of the submission of the monitored abstracts to SRS; 2) whether the exit interviews were useful; and 3) the accuracy of the monitors, i.e., whether the nurse coordinators were making changes that conformed to actual documentation in the patients' records. The following sections discuss our findings.

Timeliness of Submission

The contract with the Foundation states the monitors will be returned to the department by the 20th of the month following accomplishment of the monitoring task. The Foundation requires the nurse coordinators to return the monitors to the Foundation by the 15th of the month following the monitoring. The extra five days is used by Foundation management to review the monitors.

In our review we found 96 percent of the monitors sampled were received by SRS by the due date or within the next six days. Foundation personnel indicated they are the cause for the delay, and not the nurse coordinators, since they review the monitors prior to sending them to SRS. They indicated they will review the monitors in a more expedient manner to ensure the monitors will reach SRS at the designated time.

Conclusion - There is no adverse effect to SRS or the long-term care facilities by having a small percentage of monitors a little late. We believe there are no problems in this area.

Usefulness of Exit Interviews

Per the contract, the nurse coordinator is to conduct and document an exit interview with the facility at the completion of the monitor. All concerns/discrepancies are to be summarized according to guidelines provided by SRS.

Conclusion - Interviewing nurse coordinators and facility personnel revealed exit interviews are useful. Facility personnel are obtaining better understandings of what is required. (We did find problems concerning documentation of the interviews. This is discussed on page 61.)

Accuracy of Monitors

When doing the monitors nurse coordinators are to follow guidelines supplied by SRS. The guidelines cover every major area on the abstract. Each facility is also supplied with the guidelines. SRS held a meeting with facility personnel in February 1985 to explain changes it made in the guidelines. Nurse coordinators were informed of the changes in a separate meeting. If medical record information does not support the patient abstract form, discrepancies are circled and correct coding noted, and a clarification is to be put on the back of the form.

We took a sample of monitored abstracts, and with facility personnel, reviewed medical record information to verify the nurse coordinator's monitor. Two of the twelve facilities visited appeared to have inappropriate changes made by the nurse coordinators. We also found a letter at SRS from a facility administrator that stated the latest review did not appear appropriate. Foundation management went to the facility to review the documentation and found the nurse coordinators had made a number of inappropriate changes. The patient assessment score increased 0.1 (approximately 3 percent) as a result of the management review. The nurse coordinators were to be retrained by the Foundation. The inappropriate changes we noted at the other two facilities would not have changed the facility patient score by such a substantial amount.

A quality control review process was implemented by the Foundation in fiscal year 1984-85 per contract requirements. After each set of monitored abstracts is sent to the Foundation, a 10 percent sample is obtained. The sample contains abstracts from 50 percent of the facilities visited during that period. This ensures work by every nurse coordinator is reviewed each period, and every facility is reviewed in a twelve month period. Documentation for the sample of monitored abstracts is requested from the facility. Foundation management then compares the documentation to the nurse coordinator's monitor. If problems are found Foundation management talks to the nurse coordinator. If necessary, the coordinator will be retrained. The results of the quality control review are sent to SRS. Department staff indicated they review the results and make any necessary changes to the facility's patient assessment score determined from the nurse coordinator's monitor.

Conclusion - The facility that was reviewed by Foundation management had not yet been included in a quality control review. Since the facility was not included we do not know if the review would have identified the problem. If other problems occur and they are not identified during the quality control review, the Foundation and department should examine the quality control review procedures and adjust the procedures as necessary.

INSPECTIONS OF CARE

Inspections of care must be conducted at least annually in each long-term care facility. Inspections of care are periodic evaluations of the care and services provided to recipients in each facility. Foundation nurse coordinators observe each resident, determine adequacy of care, and appropriateness of placement, per federal requirements. The coordinator may not notify the facility of the inspection more than 48 hours prior to her visit to the facility.

Inspection of care guidelines are given to the coordinators to follow. An inspection of care form must be completed for each

patient addressing the above requirements. The coordinator is to conduct an exit interview after the inspection has been done with the provider or his/her representative. During this interview the nurse coordinator will discuss any problems or concerns noted. The department is sent a copy of each patient's form and the exit interview. SRS can request additional inspections or follow-ups if needed.

During our audit of this area, we reviewed whether: 1) nurse coordinators note the same concerns during their inspections of care as Department of Health and Environmental Sciences (DHES) personnel identify during their annual surveys; 2) all patients are reviewed and in the prescribed time limits; and 3) inappropriate placements are identified. Our findings are discussed in the following sections.

Identification of Concerns

During the annual survey conducted by DHES personnel, a sample of residents is identified in each facility. The people are observed and medical records examined to determine whether care is appropriate. Foundation nurse coordinators, on the other hand, review all patients, interview at least 10 percent of the patients, and also review medical records. When nurse coordinators review for adequacy of care they look at the cleanliness of the resident, his/her physical functioning, nutritional status, drug administration, use of physical restraints, skin condition, and bowel/bladder functions. This is a more indepth review of patients than that done by DHES.

We examined the two reviews to determine whether the same concerns are identified. Possible duplication of work between the two departments was also examined.

Conclusion - We found, on our comparison of the two reviews, nurse coordinators are not always identifying the same problems noted during the DHES survey. This is due to the different emphasis of items reviewed. Also, because the two reviews are so

different there is no duplication. We have no concerns in this area.

Number of Residents Reviewed and Timeliness

All residents are to be reviewed annually per federal regulations. We reviewed documentation for a statistical sample of residents to determine if the residents receive an inspection of care and the inspections are not more than one year apart. We did not find any significant problems in either area.

Conclusion - We conclude all residents are reviewed during the inspection of care and the reviews are done in a timely manner.

Placements

During the inspections of care nurse coordinators must indicate whether an alternative placement for residents is feasible. Also, they are to note whether alternative placement out of the facility is addressed in the discharge-planning summary for each resident and is updated quarterly. On the form to be completed for each resident, the nurse coordinator is supposed to indicate whether alternative placement is feasible and why or why not.

We took a statistical sample of the residents in thirty-three long-term care facilities to determine whether nurse coordinators are indicating if alternative placement is appropriate and if there is any follow-up of these cases. Nine of the people sampled (3.7 percent of the sample) showed alternative placement could be considered. Seven of the patients could have functioned outside the facility in 1982 or 1983 but no other services were available in the respective counties. One was considered inappropriate and later left the facility. The other person could have functioned outside the facility but family members did not want him discharged.

We also examined what follow-up is conducted by SRS of those placements that appear inappropriate. We found the case is

reviewed for possible placement into the waiver program if that is an alternative available in the community.

Conclusion - Overall we found placement appropriate in the majority of cases and for those few that were considered inappropriate, the person did not have any alternatives due to community resources. SRS follows up those cases that are considered inappropriate placement.

Documentation of Exit Conferences

In our review of the work completed by nurse coordinators, we found documentation of exit conferences is not always adequate. The contract with the Foundation contains an attachment that outlines what should be included as documentation of the conferences. For patient abstract monitor exit conferences we always found documentation but some did not meet contract criteria. For inspections of care exit conferences, we found 43 out of 71 conferences did not have a completed form as required by the department. Department personnel did not know the required form was not submitted because they did not have time to review the documentation.

By not documenting the exit conference, there is no verification the conference was held. Also, facilities have complained of the lack of documentation. Some facilities use the exit conferences for future reference to identify and monitor problems and with nothing (or very little) documented, they have no tool for their use. SRS also is not provided with a convenient summary that would indicate possible problems in the facility.

For inspection of care exit conferences, Foundation personnel did not think the standard exit conference form was needed. Department personnel say the form is to be used for documentation of both exit conferences. The form presently used by the Foundation to document inspection of care exit conference does not provide facilities with the information that is to be included in the standard form. As for the abstract monitor documentation, the nurse coordinators have not documented what they discussed.

When informed of our finding, bureau personnel indicated the Foundation was made aware of the problem. They said the Foundation distributed guidelines to each nurse coordinator explaining what documentation is required. Also, Foundation management is returning incomplete exit interviews to nurse coordinators for completion. Bureau personnel will also monitor this area more closely.

RECOMMENDATION #7

WE RECOMMEND THE DEPARTMENT REVIEW THE DOCUMENTATION FOR ALL EXIT CONFERENCES TO ENSURE DOCUMENTATION IS SUBMITTED AND ACCEPTABLE.

CHAPTER VIII

BUREAU MANAGEMENT

As mentioned in Chapter II, the Medicaid Financing Bureau administered the cost-based programs (long-term care, hospitals, and home health services) until September 1985. At that time the bureau combined with Medicaid Services Bureau (responsible for fee-based services) to form the Medicaid Bureau. During this audit we reviewed the administration of the old Medicaid Financing Bureau. The following sections discuss our findings and recommendations. The recommendations are still applicable to those areas of the Medicaid Financing Bureau that are now part of the Medicaid Bureau.

MANAGEMENT CONTROLS

During our audit of the administration of the Medicaid Financing Bureau we examined the adequacy of management controls. These controls assure proper direction and attainment of program goals. Management controls include long and short-term goals, objectives, policies, procedures, and methods to measure the bureau's performance. We found there were no goals and objectives, or policies and procedures.

Goals and Objectives

The Medicaid Financing Bureau has not adequately documented its intended direction or provided guidance to its staff through objectives directed to achieve long and short-term goals. It also has not developed standards against which bureau performance can be compared.

For programs to be most effective, staff administering the programs should have direction as to what programs are supposed to do and through what means tasks will be accomplished. Long and short-term goals and objectives can provide the needed direction and criteria for measuring program performance. Once they

are established, bureau performance should be periodically measured to ensure the goals and objectives are met.

Policies and Procedures

Although present statutes and rules provide the Medicaid Financing Bureau with guidance in some areas, there is still a need for formal policies and procedures for such areas as rate setting procedures, handling of identified provider problem areas, and prior authorization procedures for certain services. Specific policies and procedures would provide more assurance duties will be performed properly and on a consistent basis.

During our audit we found a number of examples where formal policies and procedures would have helped bureau staff:

1. three bureau staff members did not know who to transfer a call to for a request for prior authorization for hospital care;

2. confusion existed as to what dates are used for completion dates related to cost reports;

3. letters to providers regarding areas of concern are not always sent out; and

4. bureau staff must direct all questions pertaining to the establishment of the yearly reimbursement rate of long-term care facilities to the bureau chief since he is the only person that knows all the details of the formula.

Since our audit, two other bureau employees have learned the reimbursement system process. Formal policies and procedures would aid these employees, and others, in performing specific tasks, such as the reimbursement system, and would be a valuable tool for training new employees. Written policies and procedures would also be useful in cases where the only employee responsible for a given area is absent or has terminated employment.

Conclusion

A bureau can be more effective when personnel have adequate direction. Procedures are more effective when directed towards

program goals. To assure proper direction and attainment of program goals, good management controls should be established. Without these controls there cannot be a comparison of program results with program goals and plans to ensure activities of personnel are being directed properly, and the bureau is going in a desirable direction. Currently there is no way to measure bureau performance.

The administrator of the Economic Assistance Division has concurred with our observations regarding the establishment of goals and objectives. The division has begun the adoption of formal goals and objectives. When they are completed, bureau goals and objectives will be adopted. The administrator also agreed with our recommendation concerning policies and procedures. These items will be completed as staff resources are available.

RECOMMENDATION #8

WE RECOMMEND THE MEDICAID BUREAU PLACE A PRIORITY ON:

A. ESTABLISHING LONG AND SHORT-TERM GOALS AND OBJECTIVES;

B. ESTABLISHING FORMAL POLICIES AND PROCEDURES FOR THE PROGRAMS IT OPERATES; AND

C. PERIODICALLY MEASURING BUREAU PERFORMANCE TO ENSURE GOALS AND OBJECTIVES ARE BEING MET.

MONITORING CONTRACTS

As part of the management of the Medicaid Financing Bureau we looked at the contracts it enters into and monitoring of the contracts. As mentioned previously, the bureau annually enters into four contracts: one with an independent accounting firm to conduct on-site audits of specific long-term care facilities; a contract with Blue Cross of Montana to obtain cost information pertaining to home health agencies, hospitals, and nursing homes

associated with hospitals; and one contract with the Montana-Wyoming Foundation for Medical Care for preadmission screenings and another for utilization reviews in long-term care facilities. The bureau does not contract for the processing of claims; the department is responsible for that contract.

We found the contracts with the independent accounting firm and Blue Cross are adequately monitored to ensure work is completed to the satisfaction of the bureau and submitted in established time frames. Problems were noted with the monitoring of the Foundation contract for utilization reviews in long-term care facilities. Our concerns and recommendation are discussed below.

Monitoring of Foundation Contract for Long-Term Care Utilization

During our audit we found: a) items specified in the Foundation contract for long-term care utilization review were not received on time (continued stay reviews and patient abstract monitors) and the SRS staff person handling the contract did not know it; b) one contract provision was not being met (documentation of exit conferences, discussed on page 61); and c) some information submitted by the Foundation per contract provisions was not reviewed (quality control results) by the SRS staff person directly responsible for the contract. We also found the Foundation is not completing some contract provisions (continued stay reviews) in a timely manner so it is not in compliance with the contract, and as a result, SRS is not in compliance with federal regulations. SRS personnel were not aware of the timeliness problem.

By not monitoring the contract, SRS does not know if contract provisions are being met or if services specified in the contracts are being provided. The person responsible for monitoring the contract indicated nothing had been done pertaining to monitoring for a number of months because there was no time.

Contracts entered into by the department should be monitored regularly to ensure contract provisions are being met. Another

person was hired to assist the person responsible for monitoring the contract so it appears more time is now available.

In response to our concern, department personnel indicated a monitoring plan is currently being developed.

RECOMMENDATION #9

WE RECOMMEND THE MEDICAID BUREAU ACTIVELY MONITOR THE CONTRACT WITH THE MONTANA-WYOMING FOUNDATION FOR MEDICAL CARE FOR UTILIZATION REVIEWS OF LONG-TERM CARE FACILITIES.

LEVEL OF CARE MANUAL

As described in Chapter VII, the Montana-Wyoming Foundation for Medical Care (Foundation) is contracted by SRS to conduct inspections of care, continued stay reviews, abstract monitors, and prescreenings. These reviews determine each patient's level of care (skilled, intermediate, or personal) and whether the person should be admitted to, or remain in, long-term care facilities. In January 1985, SRS started writing a manual for nurse coordinators to use that defines the criteria to be used to determine the different levels of care. In December the manual still had not been written and currently Foundation staff are using different criteria for prescreenings and the other reviews. Also, if SRS can obtain agreement concerning material in the manual with Medicare officials, some payments for skilled days currently made by Medicaid might be paid by Medicare.

To use different criteria for prescreenings and the other reviews creates inconsistencies. Facilities can have people admitted under one set of criteria and evaluated as to whether the people should stay under another set. This situation is inequitable to the facilities and residents. A manual should be established so the same criteria is used for all the reviews.

We informed department personnel of our concern during the audit. They replied they plan to review and standardize the

screening and review system. The project will be accomplished as resources become available.

RECOMMENDATION #10

WE RECOMMEND THE MEDICAID BUREAU PRIORITIZE STAFF TIME SO A MANUAL DEFINING CRITERIA FOR LEVEL OF CARE IS DEVELOPED.

PERSONNEL MANAGEMENT

We also examined personnel management within the bureau. This included: 1) staff training; 2) evaluations; 3) employee job descriptions; and 4) reporting responsibilities of bureau staff. We found few problems in these areas. The following sections discuss our reviews.

Training

To ensure adequate training for employees, a formal training program should be established. A formal plan specifying needed training, or when it would be provided, has not been developed for the employees of the Medicaid Bureau. A review of personnel records revealed bureau employees receive little training. Without adequate training employees could be performing their functions inefficiently or without enough knowledge to adequately do their job.

Bureau officials indicated training has been restricted because of a limited budget. A formal plan would provide additional support for more funding.

RECOMMENDATION #11

WE RECOMMEND THE MEDICAID BUREAU DEVELOP A FORMAL PLAN TO IDENTIFY EMPLOYEE TRAINING NEEDS AND PROVIDE NECESSARY TRAINING.

Employee Evaluations

The employee evaluation process involves a preevaluation meeting to determine expectations, goals, and objectives of the employee for the upcoming six months or year. A formal evaluation takes place after the first six months of employment to determine whether items discussed in the preevaluation were met. After the six-month evaluation, annual evaluations are conducted.

Conclusion - We reviewed the preevaluation and evaluation processes for timeliness and benefit to the employees. We found the evaluations are conducted in a timely manner. Bureau employees indicated the evaluations are fair and help them in the performance of their jobs.

Employee Functions

Job descriptions are imperative to good personnel management. Updated job descriptions provide direction to personnel, establish some criteria for performance evaluations, and add formal support for staffing levels.

Conclusion - In May 1985 we compared Medicaid Financing Bureau personnel job descriptions with actual duties performed. At that time, we found each employee's formal description outlined the actual functions of bureau staff.

Since our review of this area some bureau personnel functions have changed and new policies have been implemented. Prior job descriptions agreed with the functions performed. With reorganization, bureau management should ensure new job descriptions are written to conform with any changes in individual responsibilities.

Reporting Responsibilities

The last area of personnel management we reviewed was the reporting responsibilities of individual employees to determine whether spans of control are adequate. Prior to reorganization, we found most bureau employees reported directly to the bureau

chief. At that time it did not create any problems due to the limited number of employees in the bureau. After reorganization unit supervisor positions were created with limited numbers of employees reporting to each supervisor. The supervisors report to the bureau chief.

Conclusion - The Medicaid Bureau has 30 positions allocated to it, including eight long-term care specialists located in various cities in the state. The bureau chief has five staff reporting directly to him. This span of control appears to be adequate.

CHAPTER IX

CONCLUSION

The Medicaid long-term care program is a $50 million program. A program of this magnitude should be actively administered and monitored. We found a number of areas where the bureau is adequately administering the program but we also noted some major deficiencies. These include:

1. a method of evaluating patient assessment scores affecting providers rate of reimbursement that does not follow established criteria;

2. documentation supporting the methodology of the current reimbursement system is not available;

3. review of management information that could help in identifying providers having problems with submitting correct claims is lacking; and

4. monitoring of the long-term care contract with the Montana-Wyoming Foundation for Medical Care is inadequate.

Implementing the recommendations made in this report would help the program run more efficiently and effectively. Other areas in which we made recommendations include: 1) reconciling patient identification numbers to Medicaid numbers; 2) ceasing the requirement of intermediate care facilities for the mentally retarded to submit patient abstract forms; 3) reviewing edits in the claims processing computer system; and 4) reviewing documentation for exit conferences.

Deficiencies in the administration of the Medicaid Bureau were also noted. Establishing goals and objectives, policies, and procedures would provide needed consistency and guidance to bureau staff.

As noted above, the bureau is doing an adequate job in a number of areas. These include:

1. review and use of staffing reports, cost reports, and information from the independent accounting firm;

2. approval of providers for reimbursement;

3. monitoring contracts with Blue Cross and the independent accounting firm; and

4. bureau personnel matters (evaluations, reporting responsibilities).

AGENCY RESPONSE

DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES

TED SCHWINDEN GOVERNOR

P.O. BOX 4210

STATE OF MONTANA

HELENA, MONTANA 59604

April 7, 1986

RECEIVED
APR 9 1986
MONTANA LEGISLATIVE AUDITOR

Jim Pellegrini
Deputy Legislative Auditor
Office of the Legislative Auditor
State Capitol
Helena, MT 59620

Dear Jim,

This letter is intended to respond to your recommendations resulting from the audit of the Medicaid Long-Term Care Program. These recommendations were contained in your draft report 85P-12.

I would like to offer the following in response to your comments:

RECOMMENDATION #1

WE RECOMMEND THE DEPARTMENT:

A. RUN A PERIODIC COMPUTER MATCH BETWEEN MIMS AND THE PATIENT ASSESSMENT SYSTEM; AND

B. USING THE INFORMATION GENERATED, REQUIRE LONG-TERM CARE FACILITIES TO CORRECT ANY INCORRECT PATIENT RECORD NUMBERS ON THE PATIENT ABSTRACT FORMS.

RESPONSE:

Concur. The department will request the programming used by the Auditor to run the cross check. Upon receiving the programming, we will reconcile the differences between the MIMS and patient assessment. If upon analysis the "non-eligibility" related discrepancy appears to be material, we will take steps to correct the pertinent system. In this case, the reconciliation will be repeated periodically as considered appropriate.

RECOMMENDATION #2

WE RECOMMEND THE DEPARTMENT:

A. EVALUATE SAMPLING RESULTS TO DETERMINE WHETHER CRITERIA ARE MET; AND

B. ELIMINATE THE ADJUSTMENT PROCEDURE.

RESPONSE:

A. Concur. The department has developed new evaluation criteria of the sampling results. These include criteria testing and expanded sampling.

B. Concur. The adjusting process has been eliminated.

RECOMMENDATION #3

WE RECOMMEND THE DEPARTMENT:

A. STOP REQUIRING INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED TO SUBMIT MONTHLY PATIENT ABSTRACTS; AND

B. NO LONGER REQUIRE FOUNDATION REVIEWS OF THE ABSTRACTS.

RESPONSE:

Concur. The department has instituted this recommendation.

RECOMMENDATION #4

WE RECOMMEND THE DEPARTMENT REVIEW ALL THE COMPONENTS IN THE REIMBURSEMENT FORMULA AND:

A. REBASE AND RECALCULATE ALL COMPONENTS IN THE OPERATING RATE FOR FUTURE USE;

B. COMPLETELY DOCUMENT REIMBURSEMENT FORMULA DEVELOPMENT AND CHANGES; AND

C. PERIODICALLY REVIEW AND UPDATE FORMULA COMPONENTS.

RESPONSE:

A. Partial concurrence. The department will evaluate and consider rebasing the operating rate in the future.

B. Partial concurrence. The department will completely document development and changes should they occur.

C. Concur. The department has begun the process to evaluate and update formula components.

RECOMMENDATION #5

WE RECOMMEND THE DEPARTMENT REVIEW EDITS IN THE CLAIMS PROCESSING COMPUTER SYSTEM TO ENSURE THEY ARE FUNCTIONING PROPERLY AND ALL PROCEDURES/SERVICES ARE INCLUDED.

RESPONSE:

Concur. The department will review system edits to ensure proper functioning.

RECOMMENDATION #6

WE RECOMMEND THE DEPARTMENT:

A. USE THE DENIAL REPORTS TO DETERMINE WHY PROVIDERS ARE MAKING ERRORS IN CLAIMS; AND

B. USE THE INFORMATION TO IMPROVE PROVIDER RELATIONS.

RESPONSE:

Concur. The department evaluates denials and their reasons. We will continue to work with providers and/or the system to eliminate unnecessary claims denials.

RECOMMENDATION #7

WE RECOMMEND THE DEPARTMENT REVIEW THE DOCUMENTATION FOR ALL EXIT CONFERENCES TO ENSURE DOCUMENTATION IS SUBMITTED AND ACCEPTABLE.

RESPONSE:

Concur. The department has requested additional staff resources in this area. Should they be received, we feel we will be better able to monitor this area.

RECOMMENDATION #8

WE RECOMMEND THE MEDICAID BUREAU PLACE A PRIORITY ON:

A. ESTABLISHING LONG AND SHORT-TERM GOALS AND OBJECTIVES;

B. ESTABLISHING FORMAL POLICIES AND PROCEDURES FOR THE PROGRAMS IT OPERATES; AND

C. PERIODICALLY MEASURING BUREAU PERFORMANCE TO ENSURE GOALS AND OBJECTIVES ARE BEING MET.

RESPONSE:

Concur. The Bureau has begun work on developing formal policies and procedures to accomplish goals and objectives. Once established, bureau performance will be periodically reviewed according to goals and objectives.

RECOMMENDATION #9

WE RECOMMEND THE MEDICAID BUREAU ACTIVELY MONITOR THE CONTRACT WITH THE MONTANA-WYOMING FOUNDATION FOR MEDICAL CARE FOR UTILIZATION REVIEWS OF LONG-TERM CARE FACILITIES.

RESPONSE:

Concur. The department has requested additional staff resources in the utilization control area. Should these resources be granted, additional staff time will be devoted to contract monitoring.

RECOMMENDATION #10

WE RECOMMEND THE MEDICAID BUREAU PRIORITIZE STAFF TIME SO A MANUAL DEFINING CRITERIA FOR LEVEL OF CARE IS DEVELOPED.

RESPONSE:

Partial concurrence. The Medicaid bureau will evaluate staff priorities in light of this recommendation.

RECOMMENDATION #11

WE RECOMMEND THE MEDICAID BUREAU DEVELOP A FORMAL PLAN TO IDENTIFY EMPLOYEE TRAINING NEEDS AND PROVIDE NECESSARY TRAINING.

RESPONSE:

Concur. The Bureau has contacted division training staff regarding the development of a training plan recognizing the uniqueness of the tasks and staff required as well as existing budget limitations.

I would like to thank you for the opportunity to respond to your comments. If you have any questions, please feel free to contact me or John Larson at 444-4540.

Sincerely,

Dave Lewis

Dave Lewis
Director

JL/FB/037

cc Ben Johns
Lee Tickell
John Larson